

# The Counseling Center at Davidson United Methodist Church

## Client Information

Date of Initial Visit \_\_\_\_\_ Social Security # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_-\_\_\_\_

Relationship Status:  Single  Committed  Engaged  Married  Separated  Divorced  Widowed

If married, years married \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse's Age \_\_\_\_\_

Names/Ages of children \_\_\_\_\_

If separated, divorced, or widowed, years/months \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ widowed

If single, do you have a significant relationship?  Yes  No Significance \_\_\_\_\_ How long? \_\_\_\_\_  
(boyfriend/girlfriend, committed partner, etc.)

Names/Ages of siblings \_\_\_\_\_

Recent deaths of family/friends (Relation/dates) \_\_\_\_\_

### EDUCATION

High School Diploma?  Yes  No If no, highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11

College 1 2 3 4 Name of College \_\_\_\_\_ Degree(s) \_\_\_\_\_

Graduate School 1 2 3 4 Name of School \_\_\_\_\_ Area of Study \_\_\_\_\_

Business/Technical School \_\_\_\_\_ Course of Study \_\_\_\_\_

### OCCUPATIONAL DATA

Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_

Type of Work You Do \_\_\_\_\_

### PHYSICAL AND EMOTIONAL DATA

List current illness(es) or symptoms \_\_\_\_\_

List any major surgeries, serious crises, losses, or handicaps (with dates) \_\_\_\_\_

(Continued on Reverse Side)

Last Medical Exam \_\_\_\_\_ Reason \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

Current Medications \_\_\_\_\_

Have you ever received psychotherapy, counseling, or other treatment for personal, marital, or family problems?

\_\_\_ Yes \_\_\_ No Dates \_\_\_\_\_ Name of Professional (Dr., agency, pastor, etc.) \_\_\_\_\_

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency?

\_\_\_ Yes \_\_\_ No Dates \_\_\_\_\_ Name of Professional/Agency \_\_\_\_\_

Substances Used \_\_\_\_\_

Who referred you to The Counseling Center? \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Type of Counseling: \_\_\_ Individual \_\_\_ Family \_\_\_ Group

Racial/Ethnic Identity: \_\_\_ African-American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Hispanic \_\_\_ Native American \_\_\_ Other \_\_\_\_\_

Religious Preference \_\_\_\_\_ Local Congregation \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**IMPORTANT QUESTIONS FOR YOU AND YOUR COUNSELOR**

Please describe your reason(s) for seeking help \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to have happen as a result of counseling? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY**

Counselor \_\_\_\_\_ Diagnosis \_\_\_\_\_ Agreed Upon Fee to be Paid by Client \_\_\_\_\_

Length of Visit \_\_\_ Half Hour \_\_\_ Hour \_\_\_ Hour and a Half \_\_\_ Two Hours