Claudia Thompson LPC, LMFT

Client Information *Today's Date*_____

*Name*_____ *Age*_____ *Birthdate*_____

*Best contact phone number*_____ *May I leave a message? Yes No*

*Alternate phone number*_____ *May I leave a message? Yes No*

*Address*_____

*Email address*_____
(Email is not considered a confidential means of communication.)

*Emergency contact: Name*_____ *Relationship*_____

*Phone*_____ *Address*_____

_____*Email address*_____

*Level of education*_____

*Are you currently working?*_____*Occupation/Career*_____

*Relationship status: Single*_____ *Married*_____ *Partnered*_____ *Dating*_____ *Engaged*_____
*Widowed*_____ *Other*_____

*Sexual Orientation: Heterosexual*_____ *Gay Male*_____ *Lesbian*_____ *Bisexual*_____
*Transgender*_____ *Questioning*_____ *I'd rather not say*_____

How do you define your gender? Please mark where your gender lies on line below.

Male _____ *Female*

*Ethnicity: White*_____ *Black/African American*_____ *Latina/Latino*_____ *American Indian*_____
*Asian American*_____ *Multi-racial*_____ *Other*_____

*Describe your family:*_____

_____*Use back if needed...*

*Please state your reasons for seeking counseling:*_____

_____

_____*Use back if needed...*

*What medications are you currently taking?*_____

_____

*When have you previously had counseling or psychiatric treatment?*_____

_____

*Current & previous counselor/mental health professional name(s)*_____

_____

Please indicate the degree (1 to 5) to which you have concerns about the following:

	No concerns _____				*Severe concerns*
Depression	*1*	*2*	*3*	*4*	*5*
Anxiety	*1*	*2*	*3*	*4*	*5*
Sexual concerns	*1*	*2*	*3*	*4*	*5*
Suicidal thoughts	*1*	*2*	*3*	*4*	*5*
Relationships	*1*	*2*	*3*	*4*	*5*
Stress	*1*	*2*	*3*	*4*	*5*
Anger	*1*	*2*	*3*	*4*	*5*
Family	*1*	*2*	*3*	*4*	*5*
Self-esteem	*1*	*2*	*3*	*4*	*5*
Grief	*1*	*2*	*3*	*4*	*5*
Communications	*1*	*2*	*3*	*4*	*5*
Sexuality	*1*	*2*	*3*	*4*	*5*
Religion/Spirituality	*1*	*2*	*3*	*4*	*5*
Decision making	*1*	*2*	*3*	*4*	*5*
Expressing feelings	*1*	*2*	*3*	*4*	*5*
Self-injurious behavior	*1*	*2*	*3*	*4*	*5*
Alcohol/drug use	*1*	*2*	*3*	*4*	*5*
Computer overuse	*1*	*2*	*3*	*4*	*5*
Sexual compulsion/addiction	*1*	*2*	*3*	*4*	*5*
HIV or other STD	*1*	*2*	*3*	*4*	*5*
Family violence	*1*	*2*	*3*	*4*	*5*
Sexual assault/abuse	*1*	*2*	*3*	*4*	*5*
Childhood abuse	*1*	*2*	*3*	*4*	*5*
Finances	*1*	*2*	*3*	*4*	*5*
Assertiveness	*1*	*2*	*3*	*4*	*5*
Eating Concerns/body image	*1*	*2*	*3*	*4*	*5*
Obsessive thoughts	*1*	*2*	*3*	*4*	*5*
Trauma	*1*	*2*	*3*	*4*	*5*
Physical health	*1*	*2*	*3*	*4*	*5*

How did you hear about me? Doctor referral (name) _____

*www.enhancingintimacy.com*_____ *The Therapy Directory Online* _____

Sexhelp.com (iitap) _____ *AASECT* _____ *Other* _____