

Client Information

Please fill out the information below. The information will help me understand better who you are and what you are seeking from counseling and/or life coaching. Please fill out this form as completely as possible. If you have any questions, please feel free to ask.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name _____ Age _____ Date of Birth _____ Gender M, F
Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____ Is it OK to leave a message at home? Yes, No
Occupation _____ Work Phone _____ Contact at work? Yes, No
E-mail (optional) _____ Is it OK to contact you by email? Yes, No
Marital Status: Single, Married, Co-habiting, Separated, Divorced, Widowed

Name of Spouse/Partner _____ Age _____ Date of Birth _____

Children: Name: _____ Age: _____ Lives with you? Yes, No
Name: _____ Age: _____ Lives with you? Yes, No
Name: _____ Age: _____ Lives with you? Yes, No
Name: _____ Age: _____ Lives with you? Yes, No
Name: _____ Age: _____ Lives with you? Yes, No
Name: _____ Age: _____ Lives with you? Yes, No

Among your friends and family, whom do you count on for support?

In case of an emergency: Emergency contact person _____
Phone _____ Relationship to you _____

Referred to Stephen Fife for counseling/life coaching by: _____

Section II: PREVIOUS COUNSELING AND MEDICAL HISTORY

Have you ever had treatment by a psychiatrist, psychologist, or counselor in the past? _____ Yes, _____ No
If yes, please describe the reasons for treatment.

What treatment helpful? _____ Yes, _____ No

Please list any current or previous health problems.

Please list any medications that you are currently taking (including daily dosage).

What substances do you regularly use? ___Alcohol, ___Tobacco, ___Marijuana, ___Meth, ___Cocaine
Others: _____

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please describe your primary reasons for seeking counseling/therapy.

How long has this been a concern/problem for you?

Have there been any events that are associated with this problem (traumatic event, relationship ending, etc.):

In the past, what has been helpful to you in dealing with this problem?

Are you currently suffering from any of the following? Please check **all** that apply:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> overeating | <input type="checkbox"/> restless | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> compulsive behaviors |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> depressed mood | <input type="checkbox"/> sweating | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> crying | <input type="checkbox"/> trembling/shaking | <input type="checkbox"/> anxiety | <input type="checkbox"/> recent weight loss |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> excessive drinking | <input type="checkbox"/> low motivation | <input type="checkbox"/> recent weight gain |
| <input type="checkbox"/> muscle tension | <input type="checkbox"/> distrust | <input type="checkbox"/> social withdrawal | <input type="checkbox"/> difficulty concentrating |
| <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> outbursts of temper | <input type="checkbox"/> nervous | <input type="checkbox"/> sexual dysfunction |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> dizzy or lightheaded | <input type="checkbox"/> chest pain | <input type="checkbox"/> feelings of worthlessness |
| <input type="checkbox"/> stomach problems | <input type="checkbox"/> easily distracted | <input type="checkbox"/> fatigue/loss of energy | <input type="checkbox"/> can't fall asleep |
| <input type="checkbox"/> sleeping too much | <input type="checkbox"/> obsessions | <input type="checkbox"/> compulsive behavior | <input type="checkbox"/> decreased need for sleep |
| <input type="checkbox"/> poor self-esteem | <input type="checkbox"/> family problems | <input type="checkbox"/> financial problems | <input type="checkbox"/> abusive home situation |
| <input type="checkbox"/> problems with school | <input type="checkbox"/> housing problems | <input type="checkbox"/> marital problems | <input type="checkbox"/> pain |
| <input type="checkbox"/> death of a loved one | <input type="checkbox"/> childhood trauma | <input type="checkbox"/> problems at work | <input type="checkbox"/> other traumatic events |

other(s): _____

Please describe any other information that you feel is important for the therapist to know.

Authorization for Treatment

Confidentiality:

The information on this form as well as the contents of therapy conversations will be kept confidential, unless you (the client or parent/guardian) give written consent for their release. In certain situations, therapists are required by law to inform certain individuals or agencies. Situations in which the therapist is required by law to report include: when a therapist has a knowledge of or reasonable cause to believe that child abuse or neglect is occurring (report to Child Protective Services (CPS) or a law enforcement agency), and when a therapist has a knowledge of or reasonable cause to believe that there is intent to harm self or others (report to law enforcement agency).

Payment:

Payment is collected at the time of each appointment. Appointment fees are \$100 per session conducted via phone or office visit (paid by cash or check; checks should be made out to "Stephen Fife"). The therapist does not accept or bill insurance. However, a summary statement of appointments and payments is available upon request. Clients will be charged an additional fee of \$25 for all returned checks.

Appointments and Cancellation Policy:

Typically, appointments are made weekly for 50 minutes. However, this can be modified to meet your needs. If you cannot make it to an appointment, please contact Stephen Fife. Cancellation of an appointment must occur at least 24 hours before the appointment. Clients will be billed \$50 for appointments that are cancelled with less than 24 hours notice or if clients fail to attend the appointment.

Successful Outcomes:

The success of your therapy or life coaching depends greatly on your own ability, desire, and efforts. The therapist cannot offer any guarantee of the success of your treatment. However, you can expect that the therapist will come prepared for each session with the purpose of addressing your needs and the goals you have set for yourself in counseling. You have a right to be informed about the counseling process. Please inform the therapist if you are unclear about something or if you feel that the counseling is not meeting your needs.

Questions:

If you have any questions regarding the information on this form, please feel free to ask.

Consent for Treatment:

Your signature indicates your consent for Stephen Fife to provide treatment to you and/or family members. Your signature indicates that the information you provided above is accurate and that you have read, understood, and agreed to the terms described above.

Signature

Date

Signature

Date

Parent or Guardian

Date

Therapist Signature

Date