CLIENT INFORMATION SHEET

WELLSPRING COUNSELING CENTER
FIRST UNITED METHODIST CHURCH OF PLANO
3160 E. SPRING CREEK PARKWAY
PLANO, Texas 75074
972-423-4506

Today's Date_____Date of First Session (if different)_____

First Name_____MI_____Last Name_____

Prefer to be called_____ Date of Birth_____SS#_____

Address_____City_____State____Zip_____

Home Phone_____Ok to leave message?_____

Cell Phone_____OK to leave message?_____OK to text?_____

Work Phone_____EXT_____OK to leave message?_____

Email Address_____

Employer_____Occupation_____

Physician_____Phone_____Fax_____

Emergency Contact_____Phone_____Relation_____
In case of concern for your life and safety, or the life and safety of others, your counselor may decide to notify the emergency contact person listed above. Your initials here indicate your understanding and acceptance of this._____

How were you referred to the Center?_____
May we contact the person who referred you to thank them?_____

PERSONAL INFORMATION for_____
(Name)

Age_____Birthplace_____ # Siblings_____ Birth order_____
Present marital status: (please circle) Single Married Separated Divorced Widowed Partnered
How long?_____ Highest Education Grade/Degree Completed_____
Gender: M F Ethnicity_____Faith Preference_____
Spouse/Partner Name_____Age_____Length of relationship_____
Children Name Age

_____
_____
_____
_____
_____
_____

What concerns bring you to counseling at this time?

_____
_____
_____

Symptoms (please check those that apply to you today and the past two weeks

- Anger/Aggression
- Alcohol or Drug Abuse/Other Addictions
- Depression
- Anxiety
- Loss of interest in activities or life
- Impulsivity
- Inattention
- Self Esteem Issues
- Suicidal Thoughts
- Sense of Helplessness or Hopelessness
- Irritability
- Loneliness
- Memory Problems
- Dizziness
- Headaches
- Mood Swings
- Sexual Difficulties
- Trauma
- Stress
- Sleeping Difficulties
- Eating Disorder
- Fatigue
- Worry
- Grief/Loss
- Marital/Relationship Issues
- Family Conflicts
- Parent/Child Difficulties
- Weight Gain/Loss
- Other_____
  _____

Counseling Goals

Please share up to 4 goals you are hoping to work toward in your counseling.

1._____ 2._____

3._____ 4._____

Substance Use History

Alcohol Frequency: (circle) Never Daily Weekly Monthly #per week_____

Do you currently use other drugs (marijuana, cocaine, ecstacy, heroin)? Y N

Frequency if yes_____

Do you abuse prescription drugs? Y N Frequency if yes_____

Have you ever abused any controlled substance? Y N Please provide any helpful information
_____

Medical/Mental Health History

Are you currently being treated for any medical conditions? Y N If yes, please describe._____

Please list current medications or supplements and dosages you are currently taking.

_____
_____
_____

Prescribing Physician(s) and Phone

_____
_____
_____

Previous Counseling: When_____With Whom_____

What do you like best about yourself?

_____
_____
_____