Counseling for Faculty and Staff

Institute for Health and Human Services
Appalachian State University

Client Information Form

Date_____
Client Name_____ Client Number_____
Address_____
Home Phone_____ May we leave message at this number?_____
Work Phone_____ May we leave message at this number?_____
Mobile Phone _____ May we leave message at this number?_____
Email _____ May we contact you at this email?_____

For couples:
Partner Name _____
Address_____
Home Phone_____ May we leave message at this number?_____
Work Phone_____ May we leave message at this number?_____
Mobile Phone _____ May we leave message at this number?_____
Email _____ May we contact you at this email?_____
Occupation_____ Place of work _____

For Client:
Date of Birth_____ Age_____
Male _____ Female _____
Faculty _____ Staff_____ Immediate Family Member (relationship to employee)_____

Academic Affairs_____ Business Affairs_____ Student Development_____
University Advancement_____ Chancellor's Office_____

Occupation_____ Place of work_____ Years working at ASU____

Referral Source: Self _____ Supervisor_____ Co-worker _____
Relative _____ Friend_____ Other (Specify)_____

Race/Ethnic Background (optional)_____

Emergency Contact: Name_____
Phone(s)_____

Marital Status: Single___ Married___ Significant Other____ Widowed ___ Separated ___Divorced (# of times___)
Resides with_____Relationship_____

Child Name	Age	Child Name	Age	Child Name	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

What are the issues you would like to discuss with a counselor? _____

_____

_____

_____

_____

Medical Conditions (Surgeries, serious accidents, injuries, illness, seizures, disability, other)
Current_____

_____

Past_____
none

Developmental Condition or Impairment_____

_____

Medicines	Purpose?	Dosage	When did you start the medicine?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician/Psychiatrist Name_____ Phone_____

How many days did you drink alcohol in the past week? Circle one

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐

What would you say is your average amount of consumption per week? (a drink equals 1 beer, 1 glass of wine, 1 ounce of alcohol per mixed drink)

☐ 0 drinks ☐ 1-2 drinks ☐ 3-4 drinks

☐ 5-6 drinks ☐ 7-10 drinks ☐ 11+ drinks

Do you use any drugs or medications in ways that are not currently prescribed for you? Yes☐ No☐
If Yes, which drugs or medications do you use and how often?_____

_____

_____

Do you find that you have tried to cut down on alcohol or drug use unsuccessfully? Yes☐ No☐

Do you find that it takes more alcohol or drugs to achieve the same effect? Yes☐ No☐

Has drug or alcohol use hurt your work performance, relationships, caused a blackout, legal problems, guilt, depression, decreased motivation, personality change, or other problem_____?

_____Substance use/abuse/dependence by spouse/significant other/extended family member

Client Name_____ Client Number_____

Family History (family of origin data: parents, siblings, losses, quality and emotional closeness or distance of family life, problems/strengths; current family data: problems/strengths)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous therapy

____Outpatient (Where, when, length of treatment)_____
_____
_____

____Inpatient (Where, when, length of treatment, voluntary/involuntary commitment)

_____
_____

Psychiatric history in family/extended family_____
_____
_____

History of Violence

____No significant history

____Victim/witness of physical/sexual/emotional abuse/assault/trauma_____
_____
_____
_____

____Verbal/physical acting out toward others_____
_____

____Violence toward self_____
_____

Legal Issues_____

Please check any concerns you have had in the last six months:

☐ Abuse/Assault
☐ Emotional
☐ Physical
☐ Sexual

☐ Adjustment
☐ Aging/Retirement
☐ Anger Management
☐ Anxiety/Stress
☐ Career/Work Performance
☐ Depression
☐ Developmental
☐ Eating Disorder/Weight
☐ Financial
☐ Gambling
☐ Grief/Loss
☐ Hallucinations
☐ Health/Illness
☐ Impulse Control
☐ Legal Problems
☐ Neurological Problems
☐ Obsessions/Compulsions
☐ Personality Disorder
☐ Phobia

☐ Substances: Alcohol/Drugs
☐ Abuse/Dependence
☐ Codependency
☐ Adult Children of Alcoholics

☐ Posttraumatic Stress Disorder
☐ Psychosis
☐ Racial/Cultural

☐ Relationships:
☐ Friend/Co-worker
☐ Parents/Family
☐ Partner/Children
☐ Subordinate
☐ Supervisor

☐ Self-esteem
☐ Sexual
☐ Spiritual/Religious
☐ Suicidal Behavior
☐ Suicidal Thoughts
☐ Other (Please specify)_____

Thank you for taking the time to fill out these forms.