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DBA Kathy W. Bonds, LLC

CLIENT INFORMATION FORM

This information will be treated confidentially and used only by your counselor. Please try to answer each question.

Name _____

Sex M ____ F ____ Age ____ Birth Date __/__/__ Race/Ethnicity _____

Marriage/Partner

Single__ Partner__ Married__ Divorced__ Widowed__

If partnered/married, please rate your relationship/marriage as:

Very Happy ____ Happy ____ Unsure ____ or Unhappy ____

Date of partnering/marriage _____ Ages when partnered/married: Client ____ Partner/Spouse _____

How long did you know your partner/spouse before relationship/marriage? _____

Are you currently separated ____ In the process of divorce ____?

Partner/Spouse name _____ Address _____

Phone (H)) _____ Phone (W)) _____ Phone (C) _____

Spouse's Birth date __/__/__ Partner's/Spouse's employer _____

Spouse's occupation _____

Is partner/spouse willing to come for counseling? Yes ____ No ____ Uncertain ____

If divorced, when? _____ Reason for divorce _____

If widowed, when? _____ Concerns _____

Previous partners/marriages:

Dates _____ Reason(s) for relationship/marriage ending _____

Dates _____ Reason(s) for relationship/marriage ending _____

Children

Name _____ Age _____ Sex (F or M) Living (Yes or No)

Name _____ Age _____ Sex (F or M) Living (Yes or No)

Name _____ Age _____ Sex (F or M) Living (Yes or No)

Parents

Were you raised by your biological parents? (Yes or No) If not, by whom? _____

Are your parents living? Father (Yes or No) Mother (Yes or No) Age you lost your parent _____

If living, what ages are your: Father _____ Mother _____ Living together? (Yes or No)

Were your parents divorced? (Yes or No) If yes, what was your age when they divorced? _____

Rate your parent's marriage: Unhappy ___ Average ___ Happy ___ Very Happy ___

Rate your childhood: Unhappy ___ Average ___ Happy ___ Very Happy ___

Rate your adult life: Unhappy ___ Average ___ Happy ___ Very Happy ___

As a child did you feel closer to your Father ___ Mother ___ Another parent figure ___ Who? _____

Ethnic heritage: Father _____ Mother _____

Religious preference: Father _____ Mother _____

Highest level of education completed (years): Father _____ Mother _____

Occupation: Father _____ Mother _____

Siblings

List your siblings and yourself in birth order.

First Name	Age	Sex (M/F)	Living (Y/N)	Partnered/Married Status

Describe your current relationship with your parents and/or siblings:

Health

Rate your physical health: Very Good ___ Good ___ Average ___ Declining ___ Poor ___

Height _____ Weight _____ Recent weight changes? Loss ___ Gain ___ Over how long of time _____

Sleep: No Trouble ___ Have trouble ___ Please explain _____

Date of last physical exam _____ List significant medical conditions _____

Are you presently taking medication? If so, what?

Have you ever had a "nervous breakdown" or been severely emotionally upset? (Yes or No)

Have you ever been physically abused? Yes (Yes or No) Have you ever been sexually abused? (Yes or No)

Have you had previous counseling? (Yes or No) When _____

Facility and therapist _____

Addictions

Have alcohol, drugs, or gambling ever been a problem? You ___ Spouse ___ Parents ___ Siblings ___ Other family ___

In a few words, describe the problem(s)

Has your social life, work life, or relationships changed due to drugs, alcohol, gambling, or pornography? (Yes or No)

Please Explain _____

Have you or anyone in your family ever had an eating disorder? (Yes or No)

If so, please specify _____

Educational, Vocational, and Legal History

Highest level of education completed (years): _____

Military History: ___ Branch and Years of Service _____ Wartime duty? _____

Occupation: _____ Employer: _____

Have you changed jobs recently? Reasons for the change

Briefly describe involvements, at any time, with the legal system, including dates, reasons, and results)

Current/Pending court issues: _____

Preferred Spirituality or Religious Fellowship (i.e. church, mosque, temple, or other spiritual community)

Do you participate in a faith community? If so:

Worship community _____ Location _____

Attendance per month (circle) 0 1 2 3 4 5+ Childhood religious affiliation _____

What would you like your counselor to know regarding your spiritual/religious experiences or needs?

Life Experiences

List three significant events in your life and how they were significant.

1. _____

2. _____

3. _____

What is your main reason for this visit? Who suggested you seek counseling?

Please () any of the following issues that concern you:

- | | |
|---|--|
| <input type="checkbox"/> abuse: emotional, physical, sexual | <input type="checkbox"/> decision-making |
| <input type="checkbox"/> academics (grades, performance) | <input type="checkbox"/> delusions |
| <input type="checkbox"/> addictions in your family | <input type="checkbox"/> depression, mood swings |
| <input type="checkbox"/> alcohol and/or drugs | <input type="checkbox"/> doom (overwhelming sense of) |
| <input type="checkbox"/> anger | <input type="checkbox"/> eating, appetite, food intake |
| <input type="checkbox"/> anxiety, worry, nervousness | <input type="checkbox"/> fatigue, tiredness |
| <input type="checkbox"/> childhood harm to animals/others | <input type="checkbox"/> finances |
| <input type="checkbox"/> concentration | <input type="checkbox"/> forgetfulness |
| <input type="checkbox"/> cultural adjustment | <input type="checkbox"/> gambling |

___grief, loss, death

___guilt, shame

___hallucinations

___helplessness

___homicidal thoughts

___hopelessness

___irritability

___isolation

___learning disability

___legal issues

___living situation

___medical issues

___motivation

___muscle tension

___need for control

___obsessions, compulsions

___pain (chronic)

___panic attacks

___paranoia

___phobias, fears

___pregnancy

___ADD/ADHD

___procrastination

___racing thoughts

___rape, sexual assault

___relationships

___spirituality, religion

___self-esteem, self-confidence

___self-injury: cutting, burning, suffocating

___sexual orientation and/or identity issues

___sexuality issues

___social discomfort, anxiety

___stress management

___suicidal thoughts, death wishes

___suicide attempts

___tearfulness

___time management

___trauma

___unemployment

___weight, body image

___work, job

___worthlessness

Briefly describe any of the above issues further

How long have these concerns been an issue for you?
