The Summit Counseling Center

At The Summit, we pride ourselves in being compassionate, caring, and professional guides on your path to being complete.

Client Information Form

The Summit Therapists truly care about all aspects of your well-being and the information you provide on this form helps us to learn more about you in order to serve you and help you.

******This Form is Confidential and will be kept by Your Therapist in Your Clinical File.******
You may give the form to either the front office staff or directly to your therapist

Today's date: _____Your name_____
Your child's name (if applicable): _____
Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Contact Information: From time-to-time your therapist may want to reach you.

- May I have your permission to contact you by email?
  ☐ **Yes** ☐ **No**

Email address: _____

- May I have your permission to contact you by phone?
  ☐ **Yes** ☐ **No**

Phone number: _____

(If you are here for your child please complete the following information in reference to your child.)

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____
_____
_____

Any additional information you would like to include:
_____
_____
_____

The following information will help guide your treatment. Please try to fill out as much as you are comfortable disclosing and skip areas that do not apply to your situation.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses): _____

_____

_____

Current Medications (if you need more room, please write on the back of this page**:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

If you are here for health or disordered eating habits please provide the following information:

Height:_____ Weight:_____

Briefly describe your diet and exercise patterns:_____

_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): _____

_____

_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Do you see yourself as a religious or spiritual person? If so, is spirituality important in your life?

_____

_____

Have the difficulties you are experiencing affected you religiously or spiritually? If so, in what way?

_____

_____

What do you think are your strengths?_____

_____

_____

ALCOHOL AND DRUG USE:

Do you smoke or use tobacco? YES NO If YES, how much _____ per day?
Do you consume caffeine? YES NO If YES, how much _____ per day?
Do you drink alcohol? YES NO If YES, how much _____ per day/week/month/year?

Do you use other substances? YES NO If YES, how much _____ per day/week/month/year?

Have you ever been in trouble or in risky situations because of your substance use? YES NO
If YES, please describe: _____

Do you use any non-prescription drugs? YES NO
If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use (prescription or nonprescription?) YES NO
If YES, please describe: _____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___
Are you currently employed? _____ If so, what do you do? _____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7
Any past career positions that you feel are relevant?_____

Any additional information you would like to include:

Release of Information and Consent: It is important to be very conscientious about maintaining client confidentiality while coordinating your care with others. The purpose for consent is to assist your therapist in the evaluation and/or treatment of the your presenting concerns, to be informed of or to coordinate treatment with other health care or mental health professionals, and to facilitate continuity of care at the time of discharge.

Please list any physicians, psychiatrists, or mental health professionals that you have seen in the last two years. Please also list any family members or other individuals that you wish for your therapist to be in contact.

Professionals Seen	City/State	Phone #& Fax	Approx. Dates Seen & Reason Seen

Family & Others	City/State	Phone #(s)	Relationship

AFTER GIVING DUE CONSIDERATION TO THE EXTENT OF THIS RELEASE, I AUTHORIZE MY THERAPIST TO FURNISH INFORMATION, INCLUDING PHOTOSTATIC COPIES OF MY MEDICAL / EDUCATIONAL RECORDS, CONCERNING MY HOSPITALIZATION / TREATMENT, TO THE ABOVE ORGANIZATION OR ITS AGENTS, AND I FURTHER AGREE TO INDEMIFY AND HOLD HARMLESS ITS STAFF FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED. ANY INFORMATION OBTAINED FROM THIS AUTHORIZED RELEASE SHOULD NOT BE RE-RELEASED TO ANY OTHER PERSON (S) UNLESS I SO SPECIFICALLY AUTHORIZE.

I UNDERSTAND THAT THE RECORDS RELEASED MAY CONTAIN ALCOHOL AND DRUG TREATMENT INFORMATION, AIDS/HIV OR PSYCHIATRIC / PSYCHOLOGICAL INFORMATION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, AND THAT THIS AUTHORIZATION IS VALID FOR THE DURATION OF MY TREATMENT AND EXPIRES SIX MONTHS AFTER THE TERMINATION OF SERVICES.

Client Signature	**Date**	**Witness**	**Date**

Parent/Guardian Signature (if client under age 18)	**Date**	**Relationship to Client**