The Summit Counseling Center

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

Client Information Form

We truly care about all aspects of your well-being. 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 record. *****

Today's date: **Client name**

Guardian's name (if minor client):

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 treatment (i.e. assessment, psychological testing, and 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

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

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

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

Height: Weight:

Briefly describe your diet and exercise patterns:

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? ◯ **YES** ◯ **NO** If so, what do you?

	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:

Client Signature

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

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**

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