

Passages Counseling Center ~ Client Information Form

**A. Identification**

Name \_\_\_\_\_ Date: \_\_\_\_\_

**B. Chief concern**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Treatment**

1. Have you ever received psychological or psychiatric or counseling services before? No Yes If yes, please indicate:

When?	Mental Health Professional?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

When?	Prescribing doctor?	Which medications?	For what?	With what results?

**D. Health History**

Please list any medical problems for which you have received treatment.

When?	Medical condition?	Medication?	Prescribing doctor?

**E. Chemical Use**

Have you received treatment for abuse of alcohol or drugs? If so, please explain below.

When?	Where?	For which substances?	With what results?

**F. Trauma or major loss** Please describe any history of abuse, trauma or major losses.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_