Crane Counseling Group, LLC

Providing Counseling, Consultation, and Psychological Evaluation
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Client Information Form

Welcome. As part of beginning the counseling process, please take a few minutes to fill out this form. This information will help me better understand you, and will help us both find solutions to the situations that are creating difficulties for you. Please note that this information is confidential.

Date _____

Type of services sought (Check all that apply)

__Individual

__Child / Teen

__Marital / Couple

__Family

Name of person filling out form _____

Name of Primary Client (if different) _____

Primary Phone Number _____

Secondary Phone Number (If available) _____

Primary Email Address _____

Names of individuals living in the primary household and relationship to the primary client. Please also list any immediate family members of influence to the client who are not living in the primary household of the client.

_____

_____

_____

Sources of Stress: What are the primary issues for which you are seeking counseling for yourself or your child?

1._____

2._____

3._____

What are the most important things you think I should know about these issues?

_____

_____

_____

In what ways have you attempted to cope with these issues?

_____

_____

_____

Do you or your child have any particular concerns or fears regarding therapy?

_____

_____

_____

Mental Health and Social History

Have you or anyone in the family attended therapy previously, or are currently in treatment?

Yes No

Any psychiatric hospitalizations?

Yes No

If yes, please indicate:

Dates: _____

Type of problem / condition: _____

Therapist / Program: _____

Dates of treatment: _____

Any relevant information regarding psychiatric treatment:

_____

_____

Have you, your child or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?

Yes No

If yes, please indicate circumstances and dates of treatment (if applicable):

_____

_____

Have you, your child, or anyone in the family been a victim of child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act?

Yes No

If yes, please circle whether abuse was:

Physical Sexual Emotional Domestic Other

Age abuse(s) occurred: _____

Have you, your child, or anyone in the family had trouble with alcohol or other substances, now or in the past?

Yes No

If yes, please indicate:

Substance Used: _____

Frequency / Amount: _____

Relevant details:

_____

_____

Medical History

Physician(s) currently treating primary client:

Physician's Name _____

Phone number _____

Reason _____

Physician's Name _____

Phone number _____

Reason _____

Please provide any relevant information:

_____

_____

Is anyone in the family being treated for a medical problem(s) and / or disability?

Yes No

Briefly describe:

_____

_____

Current medications or homeopathic interventions if any (for primary patient):
Medication / Dosage:

_____

Prescribing physicians:
Please describe relevant details:

_____

_____

Please provide any other relevant information below that you feel would be beneficial for me to know about yourself, your child, and your family.

_____

_____

_____

_____

Thank you very much for your time in completing this document.