WYFS Client Information Form

Welcome. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as potential solutions in helping you get your life back on track. Please note: the information is confidential.

Type of services being sought: (*Check all that apply)* **Today's Date** (Intake Date):_____
❑ Individual Adult ❑ Individual Child ❑ Marital/Couple ❑ Family

Name of person filling out form: _____ Date of Birth _____

Name of Primary Client (if different): _____ Date of Birth _____

Relationship to primary client: _____
Are you the client's emergency contact? ❑ Yes ❑ No

If no, Emergency Contact Name: _____ Phone: _____

Client Address: _____

City: _____ Zip: _____

Email address: _____
❑ Check here if you DO NOT want email reminders of appointments.

Mobile Phone: _____ Belonging to: _____
Messages: ❑ Voicemail message okay ❑ No messages

Mobile Phone: _____ Belonging to: _____
Messages: ❑ Voicemail message okay ❑ No messages

Home Phone: _____ Messages: ❑ Okay voicemail ❑ Okay other person ❑ No messages

Work Phone: _____ Messages: ❑ Okay voicemail ❑ Okay other person ❑ No messages

Other Phone: _____ Messages: ❑ Okay voicemail ❑ Okay other person ❑ No messages

Primary Client Employer or School_____

Employer/School Address: _____

Primary Client highest level of education completed: _____

Primary Care Physician(s) currently treating self/primary client:

*Name/Phone*_____

*Name/Phone*_____

*Name/Phone*_____

Current Medications for self/primary client(s):
Name *Medication/Dosage* *Prescribing Physician*

_____

_____

_____

Names of other individuals living in the primary household (Please check those who will attend counseling**)**

☑	NAME	Relation	Birth date	Employer/School	Position/Grade in School
❑					
❑					
❑					
❑					
❑					

Second Household (if applicable)
Name(s): _____

Address:_____ City: _____ Zip: _____

Phone: _____ Messages: ❑ Okay voicemail ❑ Okay other person ❑ No messages

Sources of Stress: What are the primary concerns for which you are seeking treatment?
1. _____
2. _____
3. _____

Struggles: Is anyone in the family struggling with the following? ❑**Check all that apply**

❑Parent/child conflict
❑Couple concerns
❑Anger issues
❑Depression/hopelessness
❑Anxiety/worry
❑Communication problems
❑Divorce/separation adjustment
❑Remarriage adjustment
❑Job/financial problems/unemployed
❑Housing problems
❑Partner violence/abuse
❑Sexual abuse/rape
❑Alcohol/drug concerns
❑Loss/grief
❑Legal issues
❑Eating problems
❑Sexuality/intimacy concerns
❑Suicidal thoughts/attempts
❑Major life changes

<u>Complete for Children</u>
❑Education problems
❑Truancy runaway
❑Fighting w/peers
❑Hyperactivity
❑Wetting/soiling clothing
❑Isolation/withdrawal
❑Child abuse/neglect
❑Other:_____

Some Examples of Goals: Feel happier in work, home, relationships; Make more friends; Be healthier; Manage/reduce stress; Manage/reduce intense emotions; Improve parenting skills; Improve communication; Deal with addiction; Adjust to life transition; Grieve; Increase intimacy

What are Your Goals for Counseling?

1. _____

2._____

3. _____

FAMILY HISTORY: This information is confidential.
During your intake interview with your therapist, you will have time to discuss these topics further.

Has the primary client received a mental health diagnosis in the past? ❑No ❑Yes

If yes, Diagnosis: _____ Date: _____
Doctor/Therapist/Treatment Center name: _____

Has the primary client received mental health treatment in the past? ❑No ❑Yes

If yes: *Provider Name(s)* *Year(s) treatment occurred*

_____

_____

_____

Has anyone in the family attended therapy previously or is currently in treatment? ❑No ❑Yes

Has anyone in the family had suicidal thoughts/attempts recently or in the past? ❑No ❑Yes

Has anyone in the family been a *victim* or *perpetrator* of child abuse (physical, sexual, emotional, neglect), domestic violence, rape or other violent act? ❑No ❑Yes

Do you or a family member have/had trouble with alcohol or other substances? ❑No ❑Yes

Has anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? ❑No ❑Yes

Is primary client being treated for a medical problem(s) and/or disability? ❑No ❑Yes

If primary client is in school, how is overall school performance? ❑Poor ❑Average ❑Good ❑Excellent

Is primary client receiving any special education services? ❑No ❑Yes If yes, please discuss with your therapist.

If primary client is under 18, has s/he been suspended from school in last 12 months? ❑No ❑Yes

If primary client is under 18, has s/he been arrested in the last 12 months? ❑No ❑Yes

Cultural Background: _____

Religion: ❑Catholic ❑Protestant:_____ ❑Jewish ❑Mormon ❑Buddhist ❑Muslim
❑ Spiritual but not religious ❑Other:_____
Importance of religion to you/your family: ❑Not Important ❑Somewhat important ❑Very Important

Please use the back of this form if you would like your counselor to know any additional information.