Renewed Life Counseling Services, PLLC

705 S. Ogontz St. York, PA 17403 (717) 549-4020

CLIENT SELF-REPORT FORM

THE INFORMATION ASKED FOR BELOW IS TO HELP US BETTER UNDERSTAND YOU. PLEASE FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

GENERAL INFORMATION Date:_____

Client Name: _____
Title (Dr/Mr/Mrs/Ms) First Middle Last

Date of Birth _____ Age _____ Sex: M F

Address:_____ _____ _____
Street City State Zip

Phone:(H)_____(W)_____(C)_____

Email: _____

Employer/School:_____

Occupation/Grade:_____

Education: (Last grade completed/last degree earned)_____

Religious Preference:_____ Church:_____

Who Referred You To this office?_____

Will you be using Health Insurance Benefits?	_____Yes _____ No
Health Insurance Company	
ID Number	
Name, Date of Birth, and Social Security # of Primary Insured	Name: _____ Date of Birth: _____ SSI# _____ - _____ - _____

FAMILY INFORMATION

___ Single ___ Dating ___ Engaged ___Married ___ Separated ___ Divorced ___ Remarried ___ Widowed

If Married Or In A Significant Relationship, How Many Years?_____

Spouse Or Partner's Name_____

Previous Marriages Or Significant Relationships (dates, dissolved):

Names and Ages Of Children in Order of Birth				
Name	**Age**	**Sex**	**Married?**	**Children?**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have Any Children Died? ____Yes ____No If yes, please give details:_____

_____

Father: Name_____Age____ Deceased?_____ Age At Time___ Date_____

Mother: Name_____Age____ Deceased?_____ Age At Time___ Date_____

Parents' Employer (If 18 Or Younger)

Father: _____Occupation:_____

Mother:_____Occupation:_____

|Brothers and Sisters:			
Name	**Age**	**Sex**	**Deceased (date)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact: In case of an emergency, who may we contact related to your health, safety or wellbeing?

Name	Relationship	Phone Number

Circle the following words which best describe you.

Active	Ambitious	Angry	Moody	Aggressive
Lonely	Shy	Nervous	Leader	Happy
Self-Confident	Quiet	Hardworking	Calm	Jealous
Extrovert	Sad	Submissive	Serious	Strong
Self-Conscious	Impatient	Introvert	Easygoing	
Patient	Impulsive	Excitable	Sensitive	

Have you ever been convicted of a criminal offence? Y N
Describe _____
Probation Y N Probation Officer _____

MEDICAL INFORMATION

Have You Had Previous Mental Health Therapy?_____When?_____

With Whom?_____

Have you ever received treatment for substance abuse? Y N When? _____

Are You Presently Seeing Another Therapist?_____

If So, Whom Are You Seeing?_____

Rate your Health: ____ Very Poor ___ Poor ___ Average ___ Good ___ Very Good

Are You On Medication?_____If So, Which Medication?_____
Dosage: _____
For What Condition?_____

Prescribed By? _____

Do you have problems sleeping Y N Avg Hrs./night _____ Avg Hrs/week _____

Have you experienced a traumatic event Y N _____

_____

Do you experience chronic pain Y N

Are you currently using any drugs for non-medical purposes? Y N

If so, what are you using? _____

Daily Consumption of: Caffeine _____ Nicotine _____ Alcohol _____

Major Life Events (check all that apply)

	Past Year	Past 3 Years	Past 8 Years
Relationship conflict: [ ] Family			
[ ] Spouse/Partner			
[ ] Friend			
[ ] Co-worker			
[ ] Boss			
[ ] Other			
Marriage			
Divorce			
Birth/Arrival of Child			
Death of Child			
Death of Spouse			
Death of Friend			
Change of Employment			
Major Illness			
Financial Hardship/Success			
Other _____			

CURRENT CONCERNS:

What issues do you wish to discuss or address in therapy? _____

_____

_____

_____

_____

_____