CLIENT INFORMATION SHEET

Full Name_____

Phone:_____ E-Mail_____

Age_____ Religious Preference_____

Marital History: Never married _____

1st marriage: Date(s)_____Spouse_____Children _____

2nd marriage: Date(s)_____Spouse_____Children _____

Who has custody of your minor children?_____

Have you ever considered suicide?_____ Attempted?_____

Do you suffer from: Migraines____ Epilepsy_____ Vertigo_____

Circle any of the following which are currently causing you difficulty:

Anger Health Career choices Parenting My Past Dating Self-concept Food Anxiety Sexual Problem Marriage Religion Nightmares Panic Attacks Concentration Finances Phobia Grief Work Headaches Assertiveness Suicidal thoughts Energy Abuse Addiction Parents Sleep Trouble Violence Divorce Hearing Voices Guilt Sadness Self-Control Depression Step-family In-laws Cutting Obsessiveness Legal Issues Hopelessness

What was your Father's main weakness? What was your Mother's main character's weakness?

_____ _____

_____ _____

What is your birth order? (i.e. oldest, youngest, of how many, etc.), _____

How will you be different if this work is successful? _____

_____

_____

Statement Of Confidentiality

The Client-Practitioner relationship offers confidentiality in so far as allowed by the laws of the State of Kentucky. Under certain conditions, the right to confidentiality is necessarily violated. Those conditions include the potential for suicide or homicide on the part of the client. Likewise, when there is reason to suspect that physical or sexual abuse has occurred to a child or an elderly person, the practitioner is required by law to report the situation to the Department of Human Services, division of Child Protective Services.

Thank you for completing this questionnaire.

_____ _____

Your Signature Date