Kasandra Wheeler, PLLC
LICENSED PROFESSIONAL COUNSELING

Adult Client Information Form

Today's date: _____/_____/_____

A. Identification

Your legal name: _____ Date of birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Cell number:_____

Email: _____ Age: _____ Gender: _____

Racial/ethnic identities: _____

Religious/spiritual traditions or identity: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____

Relationship: _____

C. Referral

How did you hear about us? _____

D. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name: _____

_____

Current medications and or over the counter medications that you are taking, please include dose if applicable: _____

_____

Please list any current or past injuries, illnesses, or handicaps: _____

_____

E. Your education and training

What is the highest level of education that you have completed? _____

Degrees/certificates obtained: _____

F. Employment and military experiences

□ Employed Full-Time □ Part-Time □ Unemployed □ Other

Current occupation: _____

Current employer: _____

Have you been in the military? ❑ No ❑ Yes: From: _____ to: _____ Highest rank held? _____

G. Marital/couple status

❑ Single ❑ Married: _____(years) ❑ Divorced: _____(years) ❑ Cohabitating: _____(years)
❑ Separated: _____(years) ❑ Widowed: _____(years)

H. Custody/ legal issues

Please list any custody or legal issues that you are currently involved in: _____

_____

I. Substance abuse

Please identify any substances you currently use: _____

Please identify any substances you have used in the past:_____

_____

Have you ever been in substance abuse counseling in the past: _____

_____

Does anyone in your family have any substance abuse history: _____

_____

J. Mental health history

Have you ever engaged in mental health treatment in the past, if so when: _____

_____

_____

Have you ever been hospitalized for psychiatric treatment ❑ Yes ❑ No

K. Current Problems or difficulties

Please describe the main difficulties that lead to your coming to see me: _____

_____

Checklist of Concerns (Please check any symptoms/ behaviors that you have experienced within the past three months)

__ I have no problems or concerns at this time
__ Alcohol/drugs use/abuse
__ Anxiety, nervousness, worrying
__ Codependence
__ Fatigue, tiredness, low energy
__ Friendships
__ Gender identity concerns or questions
__ Guilt, shame
__ Health, illness, medical concerns, physical problems
__ Inferiority feelings
__ Impulsiveness, loss of control, risky actions
__ Mood swings
__ Obsessions, repeated thoughts or memories
__ Panics or anxiety attacks
__ Perfectionism
__ Separation or divorce
__ Shyness, oversensitivity to criticism or rejection
__ Suicidal thoughts
__ Threats, violent actions, aggression
__ Weight and diet issues
__ Adjusting or adapting poorly
__ Anger, hostility, arguing, irritability
__ Childhood issues
__ Compulsions
__ Fears or phobias
__ Gambling
__ Grieving
__ Headaches, other kinds of pains
__ Hopelessness
__ Injuring oneself deliberately
__ Marital conflict
__ Nervousness, tension
__ Pain management, chronic pain
__ Parenting
__ Self-esteem, self-confidence
__ Sexual issues
__ Sleep problems
__ Temper problems
__ Traumatic events
__ Withdrawal, isolating
__ Work problems: Employment, "workaholism," can't keep a job, dissatisfaction, ambition
__ Attention or concentration difficulties, distractibility
__ Decision making, indecision, mixed feelings, putting off decisions and actions
__ Depression, low mood, sadness, crying, inactivity
__ Relationship problems with friends, with relatives, or at school or at work
__ Eating problems: Overeating, undereating, appetite, vomiting (see also "Weight and diet issues," below)
__ Other concerns or issues: _____

Please List Three Goals for Counseling:

1) _____

2) _____

3) _____

Would you like to receive future Kasandra Wheeler PLLC newsletters emailed to you? ❑ Yes ❑ No

Client Signature: _____ Date: _____

This is a strictly confidential patient medical record form for the use of the therapist only. Redisclosure or transfer is expressly prohibited by law.