



Student Health Services
(805) 922-6966 ext. 3212

PERSONAL COUNSELING CLIENT INFORMATION FORM

I. GENERAL INFORMATION:

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Birth Date: _____ Age: _____ Sex: _____ Male _____ Female Marital Status: _____

Current occupation, if employed: _____

Phone: _____ Is it okay to leave a message at this number? _____

May we contact you by voicemail, text message or email to remind you of your appointment? Yes ___ No ___

In case of emergency, notify: Name: _____ Phone: _____

Briefly describe why you are seeking counseling? _____

How were you referred here? ___ Self ___ Other, please explain _____

II. FAMILY HISTORY:

List children and ages: _____

List siblings and ages: _____

Parents ages: _____ With whom are you living? _____

Do any of the following pertain to any family members: if yes, who?

Alcohol/drug abuse: _____

Arrests/criminal history: _____

Emotional/behavioral issues: _____

Psychiatric hospitalizations or mental health issues: _____

Attempted/committed suicide: _____

Medical conditions (heart disease, cancer, seizures) _____

Learning/development issues: _____

III. MEDICAL HISTORY:

List any major medical conditions that you have been diagnosed with: _____

Past hospitalizations (when, where, for what): _____

Emergency room visits: _____

List any medications currently being taken (over-the-counter or prescription): _____

Allergic or adverse reactions: _____

Traumatic brain injury: Yes___ No___ Disability: _____

IV. SUBSTANCE ABUSE HISTORY (mark if applicable):

Check any of the following that apply to you now (in the past six months) and/or in the past:

Now	Past		Now	Past		Now	Past	
		Alcohol			Caffeine			Cocaine
		Ecstasy			Hallucinogens			Inhalants
		Marijuana			Methamphetamines			Opiates
		K2/ Spice			Prescription drugs			Tobacco

Have you ever sought counseling in the past including Allan Hancock College (when, how long, why):

Who was your counselor? _____

Suicidal thoughts? Yes___ No ___ Suicidal plans? Yes ___ No ___

Have you ever attempted suicide? Yes ___ No ___

If yes, how long ago? _____ How many times? _____

What method did you use? _____

Does anyone know? _____ Who _____

Have you ever been hospitalized for psychiatric reasons? _____ Voluntary/involuntary _____

V. PSYCHOLOGICAL HISTORY (mark if applicable):

Check any of the following that apply to you now (in the past six months) and/or in the past:

Now	Past		Now	Past		Now	Past	
		Alcohol/drug abuse			Amnesia			Anger/violence
		Anorexia/bulimia			Anxiety/nervousness			Apathy
		Argumentativeness			Auditory hallucinations			Bereavement
		Chronic pain			Communication problems			Counting/checking
		Cruelty to people or animals			Cultural issues			Death family member/loved one
		Death of spouse			Decreased need for sleep			Depression
		Difficulty sleeping			Dishonesty			Distorted body image
		Employment problems			Emptiness			Euphoria
		Excessive fear			Excessive sleeping			Explosive anger
		Extreme attachment to others			Fatigue			Feeling worthless
		Feeling detached			Feelings of abandonment			Financial difficulties
		Flashbacks			Gambling problems			Gender identity issues
		GLBT issues			Hoarding/difficulty throwing away items			Homicidal thoughts
		Hopelessness			Identity confusion			Impulsiveness
		Inability to concentrate			Intrusive ideas			Lack of empathy
		Lack of remorse			Learning disability			Legal problems
		Loss of appetite			Lost interest in activities			Lost memories
		Memory problems			Multiple personalities			Nightmares
		Obesity			Overreacting			Panic attacks
		Paranoia			Parent/child relationship issues			Perfectionism
		Phobias			Physical abuse of others			Poor self esteem
		Pornography			PTSD			
		Racing thoughts			Rapid mood changes			Recurring thoughts
		Religious/spiritual problems			Risky behavior			Sadness
		Seasonal mood changes			Self-importance			Self-injurious behaviors
		Self-mutilation (cutting/burning etc.)			Sexual assault/rape/molestation			Sexual problems
		Social anxiety			Suicidal thoughts			Tactile hallucinations
		Technology overuse			Test anxiety			Traumatic brain injury
		Unconcerned with safety of others			Visual hallucinations			Weight gain/loss
		Withdrawn			Irritable			Difficulty making decisions

VI. LEGAL HISTORY:

Arrests: _____
Incarceration: _____
Probation: _____
Parole: _____

VII. ACADEMIC HISTORY:

How long have you attended Allan Hancock College? _____
What are your academic goals? _____ Major? _____
Have you been on academic probation? Yes ____ No ____
Is your school work being disrupted by the problem(s) that prompted you to seek counseling? Yes ___ No ___

VIII. GOALS OF THERAPY:

What would you like to accomplish by attending therapy? _____

Client's signature

Date