

CLIENT INFORMATION FORM

Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Spouse Name: _____ Spouse's Social Security #: _____

Address Physical (include city, state, zip): _____

Address Mailing (include city, state, zip): _____

Home # () _____ Work # () _____

Cell # () _____

Email address: _____

May I contact you by e-mail? _____

Occupation: _____ Years of Education/Degree: _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred By (choose one): Insurance company (list name) _____

person/organization (list name) _____ phone book (list name) _____

Other referral (list name) _____

May I thank the referral? _____

RELEASE/PAYMENT AUTHORIZATION: I agree to provide payment in full at the time of service to Belaire Counseling Services 5536 Superior Dr. Suite C Baton Rouge, LA 70816. I authorize the release of medical information necessary to process an insurance claim on my behalf. I acknowledge that I received a copy of the HIPAA Privacy Notice.

Signed: _____ Date: _____

Belaire Counseling Services
Christine Belaire, Ph.D.
5536 Superior Dr. Suite C
Baton Rouge, LA 70816

DrBelaire@BelaireCounseling.com
www.BelaireCounseling.com
(225) 572-6041

The following are common concerns of individuals. Please check all that apply to you.

1. My family has a history of (check all that apply):

- poor communication counseling abuse
 depression hospitalization alcoholism
 eating disorders drug or gambling addiction

2. I use alcohol:

- less than once per week more than once per week never

3. I use drugs:

- less than once per week more than once per week never

4. The following have resulted from my use of alcohol/drugs (check all that apply):

- traffic violation black outs financial problems
 ruined relationship health problems work or academic problems

5. I have been in trouble with the legal system.

6. I have had an unwanted sexual experience.

7. I have experienced (check all that apply):

- emotional abuse sexual abuse physical abuse

8. I've tried to control my weight with (check all that apply):

- vomiting laxatives not eating
 diet pills excessive exercise other

9. I have thought or tried to (check all that apply):

- harm myself harm another person

10. At times, I have acted in a violent manner.

11. I have recently had problems with the following (check all that apply):

- sleeping appetite fatigue
 concentration weight loss/gain mood shifts
 headaches anxiety medical problems

12. I have difficulty (check all that apply):

- expressing my emotions controlling my anger handling stress
 accepting myself accepting compliments

13. I have experienced a recent (check all that apply):

- death relationship that ended major move

14. Sometimes I hear unwanted voices in my head.

FOR EACH ISSUE, PLACE A CHECK UNDER THE NUMBER TO DECIDE HOW MUCH EACH ISSUE HAS DISTRESSED, WORRIED, OR BOTHERED YOU IN THE PAST TWO WEEKS.

1-Notatall 2-Slight 3-Moderate 4-Considerable 5-Extreme

1	Feeling angry	1	2	3	4	5
2	Feeling timid or shy	1	2	3	4	5
3	Feeling depressed	1	2	3	4	5
4	Being easily embarrassed	1	2	3	4	5
5	Feeling like a failure	1	2	3	4	5
6	Feeling on the verge of tears	1	2	3	4	5
7	Being ill at ease with others	1	2	3	4	5
8	Feeling discouraged	1	2	3	4	5
9	Not feeling like eating	1	2	3	4	5
10	A lack of friends	1	2	3	4	5
11	Feeling shy with the opposite sex	1	2	3	4	5
12	Blame, criticize or condemn others	1	2	3	4	5
13	Difficulty holding conversations	1	2	3	4	5
14	Feeling hopeless	1	2	3	4	5
15	Headaches	1	2	3	4	5
16	Difficulty with Sleep	1	2	3	4	5
17	Stay by yourself a lot	1	2	3	4	5
18	Feeling tense and nervous	1	2	3	4	5
19	Upset stomach	1	2	3	4	5
20	Sexual problems	1	2	3	4	5
21	Suicidal thoughts	1	2	3	4	5
22	Problems with family	1	2	3	4	5
23	Upset by academic concerns	1	2	3	4	5
24	Problems with spouse or significant other	1	2	3	4	5
25	Stress related to work	1	2	3	4	5
26	Stress related to school	1	2	3	4	5
27	Being overweight	1	2	3	4	5
28	Problems with anxiety	1	2	3	4	5
29	Unhappy with living arrangements	1	2	3	4	5

Please indicate how important spiritual and religious issues are in your life.

How much do spiritual and religious concerns affect your daily decision making?

List all persons living in the home including age and relationship to you.

List all current medications you are taking including dosage, reason for taking the medication, and the physician who prescribed the medication.

In order of importance, list the goals you have for counseling? Please be as specific as possible.

1. _____
2. _____
3. _____

How many total sessions do you anticipate you will need to accomplish these goals?

1__ 2-4 __ 5-8 __ 9-12 __ 13-15 __ 16+__

Circle the number that best describes how much your concerns are interfering with your personal functioning.

(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (A great deal)