



AUSTIN PROFESSIONAL
— C O U N S E L I N G —

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Individual Client Information

Today's Date: _____

Referred by: _____

Name _____ Nickname _____

Address _____ City, State, Zip _____

Cell Phone _____ E-mail _____

Date of Birth _____ Ethnic Background _____ Gender _____

Occupation _____ Employer/School _____ Part or Full Time? _____

Relationship Status _____ Length of Time in Relationship _____ Living Together? _____

How Would you Describe the Quality of Your Current Relationship?

If have Children, Please List their Names, Ages, and Primary Place of Residence

Any Other Persons or Relatives Living in your Home?

(Optional): Name(s) of Current or Previous Therapist(s) and Dates Seen

Current Mental Health Issues, Problems and/or Diagnoses

Previous Mental Health Issues, Problems and/or Diagnoses

Names and Dosages of Any Medication you are Taking

When was the Last Time Your Medications were Revisited/Checked?

Family Physician's Name

Psychiatrist's Name

Hospitalizations?

Current and Previous Suicide Attempts/Feelings?

Current or Previous Substance Use/Abuse?

Arrests, Legal Trouble or Domestic Violence?

Current or Previous Physical Diseases or Limitations

Current Physical or Nutritional Concerns

Other Relevant Information You Would Like Me to Know About You

Emergency Contact:

Name of Nearest, Close Relative, Relationship to You, and his/her Phone Number

Please check any of the following items that concern you:

- | | |
|---|---|
| <input type="checkbox"/> Self-esteem, self-confidence | <input type="checkbox"/> Family conflicts or pressures |
| <input type="checkbox"/> Anxiety, nervousness, fears | <input type="checkbox"/> Friendship conflicts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship/marital concerns |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Shyness, being assertive |
| <input type="checkbox"/> Angry, hostile feelings | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Traumatic experiences | <input type="checkbox"/> Procrastination or motivation |
| <input type="checkbox"/> Physical distress | <input type="checkbox"/> Money/Financial issues |
| <input type="checkbox"/> Eating or appetite problems | <input type="checkbox"/> Suicidal feelings or behaviors |
| <input type="checkbox"/> Alcohol or drug problems | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Parent-child problems | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Spiritual/Existential issues | <input type="checkbox"/> Work or career concerns |

Please put a *second* check next to those that are of particular concern to you right now.

Please describe the main concerns that bring you here:

Any additional information about your current relationship or relationship status?
