Self-Unlimited Counseling & Coaching

Client Information

Client Name_____ Date_____

Date of Birth_____ Age _____

Home Address, City, Zip_____

Primary Phone Number_____ May we leave a message? [ ] Yes [ ] No

Secondary Phone Number_____ May we leave a message? [ ] Yes [ ] No

Name of Employer_____

NOTE: Written and verbal client information supplied to us is confidential, however, we cannot guarantee the security of your email messages. Initial here to confirm that you have been informed of this. _____

Email address_____

Emergency Contact

Name_____Relationship _____

Home Address, City, Zip_____

Primary Phone Number_____

Secondary Phone Number_____

How did you learn about Kelly O'Connor (Please circle what applies)

-Her Website -Psychology Today -Personal Referral -EAP/ComPsych -Other

Please briefly share what prompted you to seek counseling at this time.

_____

_____

_____

_____

_____

Family History

Birth Location?_____ Where were you raised? _____

Raised by [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other_____

Please briefly comment on the current or past relationship with parent figures (good, fair, poor, close, distant, etc.)

Mother _____

Father _____

Step-parent _____

Other _____

Please briefly comment on your relationships with your siblings (if applicable).

_____

_____

Any family history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? [ ] Yes [ ] No

Any family history of substance abuse, mental illness, suicide, or violence? [ ] Yes [ ] No

Please provide any additional family information that you feel is important_____

_____

Current Family

Which best describes your marital status?

[ ] Married, Date_____ [ ] Never Married [ ] Widowed, Date_____

[ ] Separated, Date_____ [ ] Divorced, Date_____

If you are married, which best describes your marital satisfaction? [ ] Poor [ ] Fair [ ] Good [ ] Great

Additional comments: _____

_____

_____

Do you have children? _____ If so, please briefly comment on your relationships with them.

_____

_____

Who do you currently have in your life for support?

_____

_____

_____

Spiritual or Cultural Preferences

Do you adhere to any particular religious or spiritual beliefs that you would like considered in counseling? If so please describe.

_____

_____

Medical History

List any current or significant past medications: _____

_____

Health concerns, serious illnesses or conditions, if relevant:

_____

_____

_____

Have you experienced any head injuries? [ ] Yes [ ] No

If yes, did you lose consciousness? [ ] Yes [ ] No

What was the date of your last physical? _____

Substance Abuse History (Please skip this section if there is none)

Are you currently or have you ever struggled with substance abuse? [ ] Yes [ ] No

If you answered yes, please list types of substances, frequency of use and dates of first and last use.

- _____
- _____
- _____

Have you received treatment for any substance abuse issue? [ ] Yes [ ] No

If yes please describe here.

_____

_____

Health & Hobbies

Please describe any hobbies or past times in which you enjoy engaging.

_____

_____

_____

Please share any health habits in which you engage or would like to engage in more (i.e., eating, exercise, meditation, etc.)

_____

_____

What do you hope will be different in your life as a result of your time in counseling?

_____

_____

_____

_____

_____

_____