FORTE
COUNSELING &
WELLNESS
CENTER

2250 Morriss Road, Suite 205, Flower Mound, TX 75028
940-222-0446

# Forte Client Information Form for Counseling Services

Today's date: _____

**A. Identification**

Your full name: _____ Nickname(s): _____

Date of birth: _____ Age: _____

Preferred pronouns (please circle): His/him Her/she they/them Other: _____

Social Security # (optional) : _____

Home street address: _____

Apt or Suite number: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____

E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Is it okay if we send a monthly newsletter to your e-mail: ____ yes ____ no

**B. Reason for Seeking Treatment**

What is (are) your top reasons for coming to therapy? _____

_____

_____

What goals do you have for treatment? _____

_____

Do you have any thoughts of suicide? (please circle) **Yes** **No** **Not currently but in the past**

Have you ever attempted suicide in the past? **Yes** **No**

If yes, when and please describe? _____

_____

Have you ever been diagnosed with a mental health diagnosis? **Yes** **No** **I don't know**

Are you currently under the care of a psychiatrist, psychologist, or other counselor (circle)? **Yes** **No**

If yes, which one, and please specify information and contact info:

_____

Have you ever participated in counseling before (circle) ? **Yes** **No** **I don't know**

If so, where and when?

_____

Key issues or problems right now: _____

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**C. Your medical care:** From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____ Address:

_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Please list any medical conditions: _____

_____

Has a medical doctor cleared you to exercise? ❑ Yes ❑ No
Do you have any physical restrictions set by your doctor? ❑ Yes ❑ No If yes, which ones? _____

_____

Are you taking any medications? ❑ Yes ❑ No If yes, which ones? _____

_____

_____

Have you ever had any significant injuries that required medical intervention? ❑ Yes ❑ No If yes, explain:

_____

**D. Religious and racial/ethnic identification/Family of Origin**
Please note: we ask this only to understand background information and influences – we treat, care about, and respect people from all backgrounds and religious affiliations

Current religious denomination/affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic

❑ Buddhist ❑ Hindu ❑ Atheist ❑ Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

Please briefly describe your family of origin: _____

_____

How would you describe your childhood overall? _____

_____

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**E. Your current employer**

Employer: _____ Job Title: _____

Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

How do you like the work that you do? _____

What are your career aspirations? _____

**F. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? I freely give my consent to contact one of these people in an emergency situation:

Please initial: _____

Name: _____ Phone: _____

Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you (name and number) :

_____

Please notify us if you have any changes to these emergency contacts.

**G. Your education and training**

Were you ever in any special-education classes? (If yes, which ones) _____

What was your highest level of education? _____

What field and/or vocation/craft have you studied/practiced? _____

_____

Were you ever in the military? If yes, which branch and when? _____

**H. Marital/relationship history/Sexual Orientation/Sexuallity**

Spouse's or Significant other's name: _____

Have you been divorced or re-married? (If so, how many times and when?) _____

_____

How well do you get along with your spouse or significant other? _____

Do you consider yourself (circle): Heterosexual Homosexual Bisexual Transgender Other: _____

Please write in any relational, sexual or gender identity areas or concerns that you would like to discuss: _____

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**I. Children (** Indicate those from a previous marriage or relationship with "P")

| Name | Current age | Gender | Grad |
|---|---|---|---|

**J. Trauma/Abuse history:**

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters:
P = Physical, such as beatings.
S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect.
E = Emotional, such as humiliation, etc.

Your age at abuse By whom? Effects on you? Whom did you tell?

Have you had any significant traumas in your life (circle)? **Yes** **No** **I don't know**

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If yes, please briefly describe:

_____

_____

**P. Chemical Use/Addictions/Habits/Health Care**

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____ How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use

No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. How much beer, wine, or hard liquor do you consume each week, on the average? _____

7. Are there times when you drink to unconsciousness, or run out of money as a result of drinking or taking drugs (prescription or non)? ❑ No ❑ Yes

8. Would you say that you have any addictions of any type and if so, which ones? _____

_____

Which drugs (not medications prescribed for you) have you used in the last 10 years?

_____

What **unhealthy** habits or patterns would you say that you have? _____

_____

What **healthy** habits are you trying to build? _____

_____

Do you ever restrict food, purge, hide food, or binge food (circle)? **Yes** **No**

If yes, please describe: _____

What is your current exercise routine (brief description)? _____

_____

What current specific dietary plan are you currently on and why? _____

_____

How do you currently feel about your body and overall health? _____

_____

**Q. Legal history**

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:
_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain:
_____

3. Have you ever been in trouble with the law? ❑ No ❑ Yes If yes, please explain:

_____

4. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: _____

**R. Other**

Is there anything else that you think is important related to you or your treatment?

_____

_____

**Q: Referral:** Who gave you my name to call or where did you hear about us?

Name: _____

Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you?

_____

Signature: To the best of my knowledge this information is true and I consent to treatment.

_____ Date: _____

Thank you for taking the time to fill this out. We know that it is lengthy, but we want to be thorough to offer you the best service possible.

*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.*

Please mark **1 for mild**, **2 for moderate**, **3 for severe** to the left of all that apply in last two months or currently.
Leave an item blank if it does not apply.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Depressed mood | | Confused | | Drug use | | Nausea/vomiting |
| | Anxiety | | Memory difficulties | | Binge drinking | | Weight: lbs ___ __ gain or __loss |
| | Nervousness | | Past trauma | | Fatigue | | Hallucinations |
| | Fearful | | Thoughts of dying | | Frequent nightmares | | Difficulty sleeping |
| | Worry | | Suicidal thoughts | | Over-eating | | Sexual difficulties |
| | Angry | | Loss of interest in activities/loss of pleasure | | Relational problems | | Significant lifestyle changes? |
| | Hurt | | Difficulty concentrating | | Avoidance: Feelings<br>Triggers<br>Problems | | Risky behaviors _____ |
| | Lost | | Panic attacks | | Restlessness | | Physical pain |
| | Frequently distracted | | Fear losing control | | Low self-esteem | | Controlling others |
| | Feeling guilty | | Muscle tension | | Purging food | | Loss of job |
| | Feeling punished | | Loss of appetite | | Frequent fighting | | Spiritual concerns |
| | Hopelessness | | Feeling rejected by others | | Easily startled | | Addictions – what type |
| | Hair pulling | | Feeling controlled | | Rage | | Divorce |
| | Lonely | | Bored | | Gambling problems | | Marital difficulties |
| | Emotionally numb | | Irritability | | Impulsivity | | Trouble with the law |
| | Worthlessness | | Grief | | Blackouts | | Sexually assaulted |
| | Feeling shame | | Fear crowds | | Overdosed | | Vocational uncertainty |
| | Crying | | Dislike of body | | Lying | | |
| | Intrusive thoughts | | Discouraged | | Have abused others | | Problems with children |
| | Moodiness | | Cutting | | Been Abused | | |
| | | | | | | | Others (Please list): |