Forte Counseling and Wellness Center, PLLC

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

Client Information Form for Counseling and Therapeutic Fitness Training Services at Forte

Today's date: _____

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____

Date of birth: _____ Age: ___

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: _____

Please note: E-mail and text are not considered a secure form of communication – please limit any confidential information you share in any kind of digital format

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

B. 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?

_____

C. Religious and racial/ethnic identification

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

❑ Buddhist ❑ Hindu ❑ 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:

_____

D. 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

Do you have 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:

_____

E. Your current employer

Employer: _____

Address: _____

Work phone: _____ or other means of communication _____

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

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?

Name: _____ Phone: _____

Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Were you ever in special 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. Family-of-origin history
Please briefly describe your family of origin:

I. Marital/relationship history
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?

J. Children Indicate those from a previous marriage or relationship with "P".

Name	Current age	Gender	Grade

K. What is your main difficulty that led you to counseling or therapeutic fitness training services?

L. What are you hoping to achieve by participating in counseling/fitness training?

M. What concerns do you have about counseling or fitness training?

N. Past Treatment
1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:
When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:
When? From whom? Which medications? For what? With what results?

O. 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?

P. Chemical use

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? ❑No ❑Yes

8. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes,

which and when? _____

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

_____

_____

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

_____

_____

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 an X to the left of all that apply in recent past or present.

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