Preston Hollow
Presbyterian Church

9800 Preston Rd., Dallas, TX 75230 214.368.6348 ext. 255

Client Information

Today's Date _____ Date of First Session (if different) _____

First Name _____ Middle Name or Initial _____

Last Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ OK to leave message? _____

Mobile Phone _____ OK to leave message? _____

Work Phone _____ Ext. _____ OK to leave message? _____

Birth Date _____ Email _____

Employment _____

Gender _____ Relationship Status _____ Ethnicity _____

Please list present medications _____

Physician _____ Phone _____ Fax _____

Emergency Name _____ Phone _____ Relation _____

In case of concern for your life and safety or the life and safety of others, your counselor may decide to notify the emergency contact person listed on this form. Your initials here indicate your permission and acceptance of this _____.

Would you give permission to Linda Smith to contact the person who referred you to her?

Initial your choice: Yes _____ No _____

Previous counseling, if so when and with whom _____

Please give 24 hr. notice if you need to cancel or change an appointment.

Your role in therapy is to:

- Make a commitment for change or growth
- Take responsibility for your own life
- Set goals for therapy
- Give feedback to your therapist
- Work on your own goals between sessions

Your therapist's role is to:

- Decide if his or her skills meet your need
- Facilitate your reaching your goals
- Help identify community and other psychotherapeutic resources

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Therapist:

PERSONAL INFORMATION:

Client Name:_____ Age:_____ Date completed:_____

Current Relationship Information:

Relationship Status: _____

How long in present status: _____

Present partner: _____ Age: _____ Occupation: _____

Faith group: _____

Comments about partner: _____

_____

Previous Relationships:

Name & Age:	Gender:	Dates:	How/why Ended:
_____	M / F	from:_____ to _____	_____
_____	M / F	from:_____ to _____	_____
_____	M / F	from:_____ to _____	_____
_____	M / F	from:_____ to _____	_____

Children:

Name:	Gender:	Age:	Descriptive Comments:
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____

Who is currently living in your household? _____

Family History:

Parent's name: _____ _____

Parent's age:
(if deceased, write age & date of death) _____ _____

Parent's faith group: _____ _____

Current marital status: _____ _____

How do you get along now? _____ _____

If deceased, what was *your* age then?

Comments: _____

Information on step, birth, or adoptive parents: _____

_____

Siblings:

Including yourself, list siblings in chronological order:

First Name:	Gender:	Age:	Descriptive Comments:
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____

Please give any other information about your family that seems important (including suicide, addictions, abuse or diagnosed mental illness): _____

_____

_____

Is there any history of abuse in your life? Yes_____ No _____
If yes, was it: verbal _____ emotional _____ physical _____ sexual _____
Comments: _____

_____

Check any of the following issues that are problematic to you at this time:

☐ Anxiety	☐ Depression	☐ Self Esteem	☐ Sexual Issues	☐ Religious Doubts
☐ Grief	☐ Hopelessness	☐ Irrational Fears	☐ Medical Issues	☐ Loss of Faith
☐ Stress	☐ Loneliness	☐ Substance Abuse	☐ Conflicts at Work	☐ Loss of Meaning
☐ Anger	☐ Relationship (partner/child/parent/other)		☐ Other (list):	