

Transformation Christian Counseling Center

1100 E. I-35 Frontage Road, Edmond, OK 73034

405.340.7400

Adult Client Information Form

Date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell Phone: _____

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

May we write you at your home? Yes No

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No Initial _____

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

Clinic/doctor's name: _____ Phone: _____

Address: _____

Current medications: _____

D. Your current employer

Employer: _____ Address: _____

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

E. Your education and training

Dates		Schools	Special Classes?	Adjustment to school	Did you graduate?
From	To				

F. Employment and military experiences

Dates		Name of military/employers	Job title or duties	Reason for leaving
From	To			

G. Family-of-origin history

Family Member	Living? (Y/N)	Age	Health			If deceased, cause of death
			Good	Fair	Poor	
Father						
Mother						
Brothers						
Sisters						

<i>Check condition and relationship of any blood relative who has or has had any of the conditions listed below</i>	Mother	Father	Paternal grandfather	Paternal grandmother	Paternal aunt/uncle	Maternal grandfather	Maternal grandmother	Maternal aunt/uncle	Siblings	Other _____
Allergies										
Birth Defects										
Cancer										
Colitis										
Depression										
Heart Attack										
High Blood Pressure										
Migraine										
Mental Illness										
Seizure Disorder										
Mental Retardation										
Learning/Attention Problems										
Suicide/Suicide Attempt										
Other (Specify)										

H. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

Date of current marriage: _____ Spouse's name: _____ Spouse's age: _____

I. Significant nonmarital relationships

Name of person	Person's age		Your age		Reasons for ending
	when started	when ended	when started	when ended	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

K. Counseling History

Have you been in counseling before? Yes No If yes, please explain below:

- Who was the counselor? _____
 What was the problem? _____
 How many sessions over what period of time? _____
 What were the results? _____
- Who was the counselor? _____
 What was the problem? _____
 How many sessions over what period of time? _____
 What were the results? _____

3. Who was the counselor? _____
What was the problem? _____
How many sessions over what period of time? _____
What were the results? _____

L. Personal Concerns

What are seeking help for at this time? _____

How much are you troubled by this? Circle one: constantly often somewhat not very much

Are you struggling with suicidal thoughts? Yes No If yes, how often? Circle one:
constantly often somewhat not very much

Have you tried to commit suicide in the past? Yes No If yes, when? _____

M. Spiritual Information

Would you describe yourself as a believer in Jesus Christ? Yes No In God? Yes No

Does the Bible/Christian Scripture have authority in your life? Yes No

Are you part of another religion besides Christianity? Yes No If yes, which one? _____

Are you active in a local church? Yes No If yes, which one? _____

Is your spiritual life healthy? Yes No Comment: _____

Do you think your spiritual life has any connection to your current emotional problem? Yes No

Comment: _____

Would you like to incorporate spiritual or religious beliefs in your treatment? Yes No

Would you like for prayer to be part of your counseling? Yes No

Please give any other information you feel is important about your spiritual life: _____

Signature: _____

Date: _____

This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.