Karis Counseling LLC – Kathy Pardue LPC

105 East Main St. Brenham, TX 77833 713-501-0663 www.KathyPardueLPC.com
info@KathyPardueLPC.com

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ **Date of birth:** _____

Your name: _____
Last **First** **Middle Initial**

Home street address: _____

City: _____ **State:** _____**Zip:**_____

Name of Employer:_____

Address of Employer: _____

Cell Phone: _____ **Work Phone:** _____
Home Phone: _____ **Email:** _____
Any restrictions on phone calls? _____

Referred by: _____
- If referred by another clinician, would you like for us to communicate with one another?
  Yes **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____

What are your goals for therapy? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ___

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____
_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____
_____

Height _____ Age_____ Male _____ Female _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY: Parents Living? _____ Siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

List the names and ages of those living in your household: _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Is spirituality important in your life? _____
Any diet and exercise patterns:_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

What do you think are your strengths?_____

PLEASE CHECK THE MAIN PROBLEMS:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____