Courtney Guess, LCSW
3355 Bee Caves Road #510
Austin, TX 78746
512.730.0181

CONFIDENTIAL CLIENT INFORMATION

Date: _____

Name _____ Social Security # _____

Date of Birth _____Age _____Referred by: _____

Address _____

City / State / Zip _____

Home /Cell Phone _____ Work Phone _____

E-Mail _____ Preferred method of communication_____

May we leave messages for you at these numbers? _____

Emergency contact/phone number: _____ Relationship:_____

Insurance Company _____ ID # and Group # _____

Have you ever sought counseling for in the past? ___No ___Yes (If yes, when and for how long?)_____

Have you found counseling helpful in the past? ___No ___Yes

Have you ever been hospitalized for mental health treatment? ___No ___Yes
If yes, was it voluntary? ___No ___Yes

Have you ever been admitted to residential or intensive outpatient services? ___No ___Yes
Where?_____ For how long? _____

Describe any *health* concerns: _____

_____

List *drugs/medications*, including *supplements (e.g., vitamins, herbs)*, you presently use and from whom do you get these medications from: _____

_____

If you are uncomfortable answering any questions on this form, you may leave them blank. At our initial appointment we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.

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Please describe yourself as fully as you feel comfortable:
Gender:____Male ____Female ____Transgender
____ MTF ____ FTM

Race / Ethnicity
____ African / African-American ____ Arab / Arab-American
____ Asian Pacific Islander / Asian American ____ Caucasian, European-American
____ Chicano(a), Latino(a), Hispanic ____ Mexican / Mexican-American
____ Native American or Alaskan Native ____ Southeast Asian / Southeast Asian American
____Biracial / Bicultural _____
____Multiracial / Multicultural_____
____Other_____

Relationship Status
____Single ____Married or Partnered ____Separated ____Divorced ____ Widowed ____Other

Sexual Orientation
____Bi-Sexual ____Gay or Lesbian ____Heterosexual ____Queer ____Questioning

Languages spoken: _____

Religious affiliation/spirituality: _____
Involvement: None Some /irregular Active

Do you identify as having a disability? No Yes (please specify)_____

Residence: ___**Alone** ___With Others (please specify name, age, relationship):
_____

Substance Use History: Please indicate your use of the following substances:

Substance	Amount	Frequency	First Use	Last Use
Alcohol				
Drugs				
Caffeine				
Tobacco				
Other				

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When was the last time you had more than 4 drinks on 1 occasion? _____
Have you ever experienced a black out from drinking too much alcohol?_____Yes _____No
If yes, how many? _____ Date of last black out_____
Have you ever tried to stop or reduce your alcohol / substance use? _____Yes _____No
Were you successful? ___No ___Yes

Please describe briefly the concern(s) that bring you to therapy: _____

_____

_____

_____

Please check any of the following items which concern you:

_____ Self-esteem, self-confidence
_____ Anxiety, nervousness, fears
_____ Depression, sadness
_____ Sexual concerns
_____ Anger, hostility, irritability
_____ Traumatic experience(s)
_____ Physical distress/pain
_____ Eating or appetite problems
_____ Alcohol or drug problems
_____ Sleep problems
_____ Parent-child problems
_____ Identity issues (e.g., race, gender)
_____ Other: _____

_____ Family conflicts or pressures
_____ Friendship conflicts
_____ Relationship/marital concerns
_____ Shyness, being assertive
_____ Loneliness
_____ Procrastination or motivation
_____ Gay/Lesbian/Bisexual issues
_____ Suicidal feelings, thoughts, behaviors
_____ Stress
_____ Self-control
_____ Health problems
_____ Work or career concerns
_____ Cultural issues, including acculturation

*Please put a *second* check next to those that are of *especially difficult* for you right now.

How much reluctance do you have about coming in for therapy? Please circle one:

No reluctance at all *Very little* *Some reluctance* *Quite a bit* *Strong reluctance*

How motivated are you to make changes related to improving your presenting concern? Please circle one:

No motivation at all *Very little* *Some motivation* *Quite a bit* *Strong motivation*

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PLEASE DESCRIBE YOUR GOALS FOR THERAPY:_____

_____

_____

_____

_____

_____

_____