Arizona Sexual Empowerment and Counseling Services (AZSECS)
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ADULT CLIENT INFORMATION FORM

Thank you for taking the time to fill out this form. The information you provide is confidential and will be helpful when you meet with your counselor for the first time. Please discuss any questions you may have.

Who referred you to this office? _____

Name _____Today's Date_____

Address_____
Street City State Zip

Age_____ Date of Birth____/____/____ Pronouns: _____

Home Phone:_____ May we leave a message? ◯Y es ◯No

Cell/Other Phone:_____ May we leave a message? ◯Y es ◯No

Email: _____ May we e-mail you? ◯Yes ◯No

Occupation: _____ Highest level of education _____

Current Relationship Status:
◯Married (how long_____) ◯Widowed (how long_____) ◯Divorced (how long____)
◯Separated (how long_____) ◯Living Together (how long_____) ◯Never Married

Spouse/Significant Other's Name: _____Age _____DOB ____/____/_____

Relationship History: Please provide information and duration of additional marriages and/or significant relationships.

_____
_____
_____

Children's Names: please list name, birth date, age, gender, and whether they live with you. N/A: ___

Name	Birth Date	Age	Gender Identity	Living with you?

What are you seeking counseling for? What do you hope to gain? :

_____
_____
_____

PSYCHOSOCIAL INFORMATION

Name: _____ **Date:** _____

Health and Personal Information:

Please describe your current physical health: ◯Excellent ◯Good ◯Fair ◯Poor

Please describe your current diet: ◯Excellent ◯Good ◯Fair ◯Poor

How many hours do you sleep at night? _____ Do you work out regularly?◯Yes ◯No

Do you smoke or use other tobacco products? ◯Yes ◯No
If so, please specify _____

Do you drink alcoholic beverages? ◯Yes ◯No
If so, please specify _____

Do you use recreational drugs? ◯Yes ◯No
If so, please specify _____

Do you currently have any physical problems, medical conditions, or disabilities? ◯Yes ◯No

If so, please explain _____

Have you ever been diagnosed, treated, or hospitalized for a mental illness? ◯Yes ◯No

If so, please provide dates, reasons, and treatment providers _____
_____

Are you on any medications? ◯Yes ◯No If so, please provide the following information:

Medication	Dosage	Physician	Purpose	How long

Have you participated in counseling before? ◯Yes ◯No If so, please provide dates and reasons:_____
_____
_____

Are you a survivor of any of the following forms of abuse? ◯Emotional ◯Sexual ◯Physical

History of substance abuse or addiction? ◯Yes ◯No If so, please explain: _____

Legal History (arrests, prison, DWI, Parking tickets)? ◯Yes ◯No Please provide dates and reasons:
_____
_____

Are you experiencing any of these common problems or symptoms? 1=mild 2=moderate 3=severe

____ Relationship(s)	____ Affair	____ Alcohol/drugs	____ Mood swings	____ Hallucinations
____ Divorce/separation	____ Finances	____ Stress control	____ Other addictions	____ Eating disorder
____ Being single	____ God/Faith	____ Fatigue	____ Grief/loss	____ Hopelessness
____ Sexual issues	____ Weight	____ Self-Mutilation	____ Loneliness	____ Depression
____ Marriage	____ Attention	____ Self-esteem	____ Fear/anxiety	____ Hearing voices
____ School/career	____ Irritability	____ Concentration	____ Pornography	____ Loss of interest

Do you possess any of these virtues/strengths?

____ Creativity	____ Curiosity	____ Open-minded	____ Learning	____ Self-control
____ Bravery	____ Persistence	____ Integrity	____ Vitality	____ Humility
____ Love	____ Kindness	____ Responsibility	____ Fairness	____ Mercy
____ Leadership	____ Hope	____ Faith	____ Humor	____ Vitality

Spiritual Information: Are spiritual/religious matters important to you? ◯ Yes ◯ No
Are you affiliated with a spiritual/religious group? ◯ Yes ◯ No Describe: _____

Support Network:
____ Spouse/Partner ____ Family ____ Friends ____ Church/Mosque/Temple ____ Other

Hobbies, special interests, sports, and leisure activities: _____

Family Social Information:
I would describe my friendships as: ◯Close ◯Somewhat Close ◯Distant ◯Conflicted
I would describe relationship with my mother as ◯Close ◯Somewhat Close ◯Distant ◯Conflicted
I would describe relationship with my father as: ◯Close ◯Somewhat Close ◯Distant ◯Conflicted
On average how many times per month do you socialize with family? _____ with friends? _____

Please provide the following information about your siblings:

First Name	Brother or Sister	Age	How would you describe your relationship?

Family Mental Health History: Please identify family members with the specified mental health history:

Mental Health Issue	Yes/No	If yes, list relationship i.e. mother, grandfather, aunt, etc.
Alcohol/Substance Abuse		
Anxiety		
Bipolar		
Depression		
Domestic Violence		
Eating Disorders		
Obsessive Compulsive Behavior		
Schizophrenia		
Suicide Attempts		
Obesity		

Crisis Information: Are you having any current suicidal thoughts, feelings, or actions? ◯Yes ◯No
If yes, explain_____

Any current homicidal or violent thoughts or feelings, or anger-control problems? ◯Yes ◯No
If yes, explain_____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? ◯Yes ◯No
If yes, explain _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? ◯Yes ◯No
If yes, describe_____

Emergency Contact:
Name:_____ Relationship:_____

Contact Number:_____ Email: _____

I understand that this person may be contacted if I miss appointments and cannot be reached. (Initial) _____