



Family Counseling Service of Northern Utah

A United Way agency serving Weber, Morgan, Box Elder & Davis counties

(Revised November 2015)

CLIENT PROBLEM SHEET

Client Name:

Instructions - In order to provide the best counseling possible to you, please describe in detail the problem(s) which have caused you to seek treatment. (Anything you can tell us about the problem is helpful, for example, what the problem is, how long you have been experiencing it, how has/is it affecting you, what you have done to cope with it in the past, etc.).



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PERSONAL HISTORY FORM

CLIENT DEMOGRAPHIC INFORMATION

Client Name: Male Female

Age (Yrs.): 0-5 6-11 12-17 18-23 24-44 45-54 55-69 70 or over

Ethnicity : White Hispanic African American Asian Pacific Islander
 Native American Other

County of Residence: Weber Davis Morgan Box Elder
 Other

Are you a refugee: Yes No

Yearly Gross Family Income: \$0 - \$9,999 \$10,000 – \$14,999
 \$15,000 - \$24,999 \$25,000 - \$34,999 \$35,000+

OTHER HOUSEHOLD INFORMATION

Amount of Other Yearly Household Income (Alimony, Child Support, SSI, Public Assistance, Pensions, etc.)	Enter Amount: \$
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Other People Living in the Household

Name	Sex	Date of Birth	Age
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		

COUNSELING INFORMATION

Presenting Problems

- 1. Depression
- 2. Bereavement/Loss
- 3. Communication
- 4. Domestic Violence
- 5. Hopelessness
- 6. Work Problems
- 7. Parent Problems
- 8. Substance Abuse
- 9. Problems w/ School

- 10. Marriage/Relationship/Family
- 11. Thoughts of Hurting Yourself
- 12. Angry Feelings
- 13. Sexual Abuse
- 14. Emotional Abuse
- 15. Physical abuse
- 16. Problems with the Law
- 17. Unhappy with your Life
- 18. Anxiety
- 19. Other _____

How Many People To Receive Counseling?

Counseling Primarily For:

Individual Couple Family

Have you received counseling at Family Counseling Service before? No Yes If so, Year _____

How were you referred? Yellow Pages Walk-In Hospital Other _____
 Family Member Self Court or DCFS Referral Internet

Have you ever tried to purposely take your life? Yes No
If Yes, how many times: _____ Date of most recent attempt: _____



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Are you currently thinking of taking your life?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Initials _____	
Have you ever been hospitalized for psychological reasons?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, how many times? _____ Date of most recent hospitalization: _____			
Have you ever or do you currently have a substance abuse problem?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, What type of substances?			
Type of Substance	Have you used in this substance in last 30 days?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever attended counseling before?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, how many times have you started counseling? _____			
If Yes, how successful has past counseling been for you?			
<input type="checkbox"/> Mostly Unsuccessful <input type="checkbox"/> Somewhat Unsuccessful <input type="checkbox"/> Somewhat Successful <input type="checkbox"/> Mostly Successful			
If Yes, please list briefly why you stopped attending counseling in the past:			
<hr/> <hr/> <hr/>			
HEALTH INFORMATION			
How would you rate your current health?		<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent	
Have you been hospitalized for other than psychological reasons for more than 24 hours in the past five years?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, what was the reason? _____			
Other than normal childhood illnesses, any serious illnesses while growing up?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what were they? _____			
Are you currently taking prescribed medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, list the medication, purpose, dosage if known, and when started.			
Medication Name	Purpose	Dosage, if known	When Started
Are you currently experiencing any changes in your eating habits?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Explain: _____			
Are you currently experiencing any changes in your sleeping patterns?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Explain: _____			
Have you ever deliberately cut or injured your body?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please discuss this with your counselor.			
Have you ever suffered a serious head injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently experiencing serious after effects of any illness or injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	



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If Yes, describe the symptoms: _____

Do you have any special health concerns that you think your counselor should know? Yes No
If Yes, describe the concerns: _____

MENTAL HEALTH INFORMATION

Have you ever been diagnosed as clinically depressed? Yes No

If Yes, what year was the diagnosis made? _____

Do you think you are currently depressed? Yes No

If Yes, please rate in your estimation how depressed you currently feel?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

If Yes, How long have you felt this way? _____

If Yes, list all the depression symptoms you are currently experiencing.

If Yes, if you are taking medication(s), have they relieved your symptoms? Yes No

If No or if you have discontinued taking the medication, explain the reason:

Has a specific event or incident caused your depression? Yes No

Have you ever been diagnosed as Bi-Polar? Yes No

If Yes, have you ever taken medication for having Bi-Polar condition? Yes No

If Yes, list the medication(s)? _____

Have you ever been clinically diagnosed with a Borderline Personality condition? Yes No

If Yes, what year was the diagnosis made? _____

SOCIAL HISTORY

How many times have you been married?

How many significant relationships, not including marriage have you had? _____

Are you currently married or in a significant relationship?

Yes No

If Yes, how long have you been married or in a significant relationship?

Did any of the adults that raised you have a substance or alcohol problem?

Yes No

When growing up did you move from place to place a lot?

Yes No

Where were you primarily raised? _____

How do you get along with your siblings?

Very Distant Relationship Somewhat Distant Relationship

Somewhat Close Relationship Close Relationship

Do you currently have a good support system? Yes No



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Has it generally been easy for you to make friends? Yes No

When you were growing up did anything particularly upsetting happen to you? Yes No

BEFORE the age of 18 were you a victim of:

Sexual Abuse Yes No

Physical Abuse Yes No

Emotional Abuse Yes No

If Yes, what was the relationship of the perpetrator to you? _____

Was the abuse reported? Yes No

AFTER the age of 18 were you a victim of:

Sexual Abuse Yes No

Physical Abuse Yes No

Emotional Abuse Yes No

If Yes, what was the relationship of the perpetrator to you? _____

Was the abuse reported? Yes No

EDUCATION INFORMATION

Did you complete high school? Yes No

If Yes, what year did you complete high school _____

If No, did you earn a GED? _____ Yes No

If Yes, what year did you earn a GED? _____

What is the highest educational grade you have completed? _____

Do you have difficulties reading or writing? _____ Yes No

Were you ever suspended or expelled from school? _____ Yes No

If Yes, How many times? _____

If Yes, for what reasons were you suspended / expelled?

Did you receive any awards in school? Yes No

If Yes, list what awards you received:

What did/do you feel about school?

Disliked it very much Disliked it Liked it Liked it very much

LEGAL INFORMATION

Do you currently have a civil or criminal case pending? Yes No

Is counseling here at FCS part of a court, probation or parole requirement? Yes No



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If Yes, provide basic details and contact information (name, phone #) _____

Note: there is an additional fee for counselor reports or letters

As an adult or juvenile, have you ever been arrested for reasons other than traffic tickets?

Yes No

If No, SKIP THE REST OF THIS LEGAL SECTION!!

If Yes, How many total arrests as a juvenile? _____

If Yes, How many total arrests as an adult? _____

Have you ever spent more than 24 hours in jail or prison? _____

Yes No

If Yes, How many times were you incarcerated for more than 24 hours? _____

If Yes, Indicate the length of the longest period of time you were incarcerated. _____

Have you ever been on probation or parole? _____

Yes No

If Yes, are you currently on probation or parole? _____

Yes No

If Yes, list your probation officer's name and telephone number:

Probation/Parole Officer's Name _____

Telephone Number _____

VETERAN STATUS

Are you a veteran of the Armed Forces? _____

Yes No

If Yes, What branch of service: Air Force Army Navy Marine

If Yes, Date of Service: _____

Have you ever served in a theater of conflict as a combat veteran? _____

Yes No

If Yes, What theater? _____

. When: _____

EMPLOYMENT INFORMATION

Are you currently employed full-time? _____

Yes No

Are you currently employed part-time? _____

Yes No

If not currently employed, how long have you been unemployed? _____

How many jobs have you held in the last five years? _____

What is the longest period of time you have worked at one job in the last 5 years? _____

Have you been terminated from any job in the last three years? _____

Yes No

If Yes, How many times were you terminated? _____

If Yes, What were the reasons you were terminated from employment:

CLIENT'S PERSONAL ASSESSMENT AND GOALS

In your estimation, how serious do you feel or believe your current problems(s) are?

(Mild) 1 2 3 4 5 6 7 8 9 (10 Severe)

In your estimation, what is your level of motivation to work out your current problems(s)?



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(Weak) 1 2 3 4 5 6 7 8 9 (10 Strong)

How many counseling sessions do you think will be necessary to work through your problems successfully?

1-3 Sessions 4-7 Sessions 8-11 Sessions 12+ Sessions

Do you understand that there are no “magical, quick fixes” for most counseling problems?

Yes No

What are your specific goals for treatment?

1.

2.

3.

Client Comments: Is there anything else about you that you believe we should know about that has not been covered in this form? Are there any additional comments you wish to make? If so, you may use the space below to describe them:

Client or Client's Guardian Signature

Date

Therapist: _____

Date



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CLIENT RIGHTS AND RESPONSIBILITIES

As clients in treatment here at FCS, it is important that you know your rights and responsibilities. After reading, please sign this document to acknowledge that you have read it and understand your rights as a client.

1. The records and information of both current and former clients will not be disclosed to parties outside FCS without written permission of the client. The exceptions to release of confidential information are explained in the Privacy Rights Notice that all clients must sign at time of Intake.
2. As a private agency, FCS reserves the right to deny or terminate services to any individual applying for services or a client receiving services. In all cases, only the Executive Director has the authority to permanently deny or terminate services.
3. Any denial of services will not be based on discrimination due to creed, ethnicity, gender, age or sexual orientation.
4. Reasons for termination or denial of treatment include, but are not limited to: (1) foul or abusive language or behavior that is rude, demeaning or threatening to FCS staff, FCS Trustees, clients, or FCS associates (2) destruction of FCS property (3) a systematic pattern of canceling appointments, late cancellation of appointments or not showing for scheduled appointments. Generally, **two such incidents in a three month period are grounds for termination of services** (4) the treatment needs of the individual exceed the ability FCS to provide (5) it is reasonably believed by the Executive Director the client poses a potentially significant risk to FCS staff, FCS Trustees, clients, or FCS associates (6) The client is actively psychotic (7) the client has reached the maximum benefit of treatment (8) failure to retire an outstanding account.
5. Currently, FCS receives support from a private foundation which requires that funding be discontinued if a client does not show up for an appointment or late cancels more than once. Such clients must wait 60 days before reapplying for funding. A client who has demonstrated little motivation in treatment, or who indicates minimal benefit from the treatment process, may be denied readmission to the foundation's treatment coverage.
6. While on FCS premises, clients are in a safe, therapeutic environment where they are free from potential harm or acts of violence.
7. Clients are expected to arrive on time for their scheduled appointments, to be appropriately dressed for the season and not under the influence of alcohol or illegal drugs.



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8. Payment is expected at the time of service unless prior arrangements have been made. Appointments cannot be scheduled if the client is behind in payments without prior authorization from the Executive Director.
9. Clients with complaints about FCS office personnel or policies are encouraged to inform the Executive Director of their concerns. The Executive Director is responsible for investigating client complaints, taking corrective action when warranted and informing the client of the results of the Executive Director's investigation.
10. Clients with complaints about their therapist are encouraged to inform the Executive Director of their concerns. The Executive Director is responsible for investigating such client complaints, taking corrective action when warranted and informing the client of the results of the Clinical Director's investigation.
11. At all times, FCS clients will be treated with dignity and free from any form of discrimination.
12. Consistent with the Utah Clean Air Act, smoking is not permitted anytime, or for any reason in FCS offices.
13. **I, the undersigned, have read and understand my rights and responsibilities and I agree with Family Counseling Service terms and conditions.**

Client or Responsible Party Signature

Date