Restoration Counseling
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Client Information

Name:_____Birthdate:_____Gender: __

Address: _____

Is it safe to send correspondence to this address if needed? ☐Yes ☐No

Phone: (Home)_____(Work)_____(Cell) _____

Is it safe to contact/leave you a message at these numbers? ☐Yes ☐No

E-mail: _____ Is it okay to email you? ☐Yes ☐No

Highest Level of Education: _____ Occupation: _____

Place of Employment: _____ Level of Income (optional): _____

Relationship Status:_____Spouse/Significant Other's Name: _____

How did you hear about Restoration Counseling? _____

Persons Living With You

Relationship	Name	Gender	Age	Quality of Relationship
		☐F ☐M		☐Poor ☐Average ☐Good
		☐F ☐M		☐Poor ☐Average ☐Good
		☐F ☐M		☐Poor ☐Average ☐Good
		☐F ☐M		☐Poor ☐Average ☐Good
		☐F ☐M		☐Poor ☐Average ☐Good

Social Relationships

Check how you generally get along with other people: (check all that apply)

☐Affectionate	☐Aggressive	☐Avoidant
☐Fight/argue often	☐Outgoing	☐Follower
☐Friendly	☐Leader	☐Shy/ withdrawn
☐Submissive	☐Other:	

Please list all individuals you would consider to be a part of your support system (family, friends, etc):

_____

_____

_____

_____

Have you recently experienced any losses or changes in relationships? ☐Yes ☐No

If yes, please describe: _____

Spiritual/Religious

Religious affiliation(s):_____Practicing: ☐Yes ☐No

How important are spiritual matters to you? ☐Not ☐Somewhat ☐Moderately ☐Very

Are you personally affiliated with a spiritual or religious group? ☐Yes ☐No

If yes, describe: _____

Were you raised within a spiritual or religious group? ☐Yes ☐No

If yes, describe: _____

Would you like for your spiritual beliefs to be incorporated into the counseling session(s)?

☐Yes ☐No

Please identify any additional related information you'd like me to be aware of:

_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong to? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐Yes ☐No

If yes, describe: _____

Other cultural/ethnic information you'd like to have known: _____

Legal

Are you involved in any active cases (traffic, civil, criminal, CPS, probation)? ☐Yes ☐No

If yes, please describe and indicate the court and hearing/trial dates and/or charges: _____

_____

_____

Have you ever been charged with a felony conviction? ☐Yes ☐No

If yes, please describe: _____

Are you presently on probation or parole? ☐Yes ☐No

If yes, please describe: _____

Military

Military experience? ☐Yes ☐No Combat experience? ☐Yes ☐No

Where: _____Branch: _____

Discharge date: _____ Discharge type: _____

Date drafted/enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical

List any current health conditions: _____

_____

_____

_____

List your current medications:

Current Medication(s)	Dose	Last Taken	Purpose	Side Effect(s)	As prescribed, overused, or underused?

Suicide/Self Harm:

Have you ever considered suicide? ☐Yes ☐No Have you attempted suicide? ☐Yes ☐No

Have you considered suicide within the last 60 days? ☐Yes ☐No

Have you attempted suicide in the last 60 days? ☐Yes ☐No

Are you currently considering suicide? ☐Yes ☐No

Do you have a specific plan that you could describe? _____

_____

What are your primary means of self-harm (e.g., cutting, burning, eating disorder, etc.)?

Primary: _____ Secondary: _____ Tertiary: _____

Have you harmed yourself in the last 60 days? ☐Yes ☐No

If yes, please describe: _____

Alcohol/Drug Use:

How often to you have a drink containing alcohol? _____

When you drink, how many drinks do you have? _____

How often do you binge drink (6 or more at a time)? _____

Please list all drugs that are currently in use (including marijuana and prescriptions not listed above): _____

_____

_____

If you have a history of drug use, please list the time frame and types of drugs that were in use:

_____

_____

_____

What is your longest period of sobriety? _____

Are you a tobacco user? ☐Yes ☐No

If so, what do you use? _____ How Often? _____

Psychosis/Harm to Others

Have you had thoughts of harming others in the last 60 days? ☐Yes ☐No

If yes, please describe: _____

Have you ever experienced auditory, visual, or tactile hallucinations? ☐Yes ☐No

If yes, please describe: _____

Are you currently experiencing auditory, visual, or tactile hallucinations? ☐Yes ☐No

If yes, please describe: _____

Psychosocial History

Please check behaviors which apply to you in the last 4-6 weeks:

☐Anger	☐Fatigue	☐Recurring thoughts
☐Alcohol dependency	☐Gambling	☐Sexual Addiction
☐Antisocial behavior	☐Hallucinations	☐Sexual Difficulties
☐Anxiety	☐Heart Palpitations	☐Sick Often
☐Avoiding people	☐High blood pressure	☐Sleeping problems
☐Chest pain	☐Hopelessness	☐Speech problems
☐Cyber Addiction	☐Impulsivity	☐Suicidal thoughts
☐Depression	☐Irritability	☐Disorganized thoughts
☐Aggression	☐Elevated Mood	☐Phobias/Fears
☐Disoriented	☐Judgment errors	☐Trembling
☐Distractibility	☐Loneliness	☐Isolation/Withdrawing
☐Dizziness	☐Memory Impairment	☐Worrying
☐Drug Dependence	☐Mood Shifts	☐Binge eating/under eating
☐Pain Attacks	☐Other:	

Prior Treatment

Have you ever received counseling/psychiatric treatment before? ☐Yes ☐No

If yes, please describe (inpatient and outpatient): _____

Client History

Please select all that apply to your history:

☐ Physical Abuse	Age:_____ Was this reported? _____
☐Sexual Abuse	Age:_____ Was this reported? _____
☐ Emotional Abuse	Age:_____ Was this reported? _____
☐ Neglect	Age:_____ Was this reported? _____
☐ Drug Abuse	Age:_____
☐Alcoholism	Age:_____
☐Domestic Violence	Age:_____
☐Psychiatric Difficulties	Age:_____
☐Criminal Difficulties	Age:_____
☐Other: _____	Age:_____

Family History

Please select all that apply to your family history (immediate and extended family):

☐Physical Abuse	Family Member / Age: _____
☐ Sexual Abuse	Family Member / Age: _____
☐ Emotional Abuse	Family Member / Age: _____
☐ Neglect	Family Member / Age: _____
☐ Drug Abuse	Family Member / Age: _____
☐ Alcoholism	Family Member / Age: _____
☐ Domestic Violence	Family Member / Age: _____
☐ Psychiatric Difficulties	Family Member / Age: _____
☐ Criminal Difficulties	Family Member / Age: _____
☐ Other: _____	Family Member / Age: _____

**Please provide the following information for safety reasons in case of emergency:*

*Car make/model:*_____ *License plate #:* _____