BETH M. WARREN, MA., LPC-S
Denton, TX
972-523-7322
bethwarrenlpc@gmail.com

CLIENT INFORMATION

Date: _____

Name: _____
First Middle Last

Address: _____

_____

Date of Birth: _____ E-mail: _____

Phone: ( ) _____( ) _____
Home Cell

May I contact you at these numbers? Yes No Which number is preferred? _____

Spouse/Guardian Information

Name: _____
First Middle Last

Date of Birth: _____ E-Mail: _____

Phone: (_____)_____(____)_____
Home Cell

Other Information:

Briefly, describe the issue(s) that caused you to seek counseling:

Have you sought counseling in the past? _____ What was the duration and outcome of past counseling experience? (Please include the name of the person you saw, dates of counseling, and outcome of counseling):

Do you have any history of abuse? _____ What Type? Physical Emotional Sexual

Have you experienced any loss such as a death or any trauma in the past 5 years? If so, please describe:

Employment Information:

Employer's Name: _____ Position held: _____

Spouse's Employer: _____ Position held: _____

Medical Information:

Current Medications: _____

Do you have any current health problems or recent illnesses or operations?

How often do you currently use alcohol and how much do you consume at a time?

Do you use tobacco, and if so, how often? _____

Do you have any history in the past 10 years of drug use, and if so, what kind and how often?

Are you currently using any drugs, and if so, what kind and how often?

Is there any history of alcohol of drug abuse in your family, either currently, or in your family of origin?

How many hours do you sleep at night? _____ Do you have difficulty sleeping?

_____

Have you gained or lost more than 10 pounds in the past year? _____
Was it Intentional? _____

Have you ever attempted to end your own life?

_____
When and what happened? _____

_____

In the past two months, have you experiences any of the following:

Yes	No	
____	_____	Jittery, nervous feelings
____	_____	Shortness of breathe
____	_____	Heart racing
_____	____	Thoughts of wishing to be dead
_____	____	Thoughts of ending your own life
_____	____	Desire to cut or self-mutilate
_____	_____	Actions of cutting
_____	_____	Feelings of rage
_____	_____	Feelings of hopelessness
_____	_____	Feelings of loneliness
_____	_____	Feelings of sadness

Family History

How old are your parents? _____

If you have lost your parents, when did you lose them and how old were you?

Are your parents divorced? _____ How old were you when they divorced?

_____ Remarried? _____

Number of siblings, names, and ages? _____

Would you describe your family as: Warm Average Hostile

Would you say your family: Allowed great independence Average Controlled

Date of your current marriage: _____ Age when married? _____

Briefly give information about previous marriages, date, and length:

Dependents:

Name	Relations	DOB
Name	Relations	DOB
Name	Relations	DOB

Is there any other information you would like me to know? _____

Church Affiliation: _____

Who referred you: _____

May I send them a thank you note: Yes No