BRIDGES COUNSELING of Ohio

CLIENT INFORMATION SHEET

Thank you for considering Bridges Counseling of Ohio for counseling.
Please fill out the Client Information Sheet and bring it to your first appointment.

NAME

first middle initial last

DATE OF BIRTH EMAIL

ADDRESS

PHONE message ok? ☐ home

message ok? ☐ cell

message ok? ☐ work

RELATIONSHIP STATUS

EMPLOYMENT ☐ FT ☐ PT ☐ STUDENT ☐ NONE ☐ OTHER

EMERGENCY CONTACT NAME

PHONE RELATIONSHIP

HOW DID YOU FIND BRIDGES? ☐ GOOGLE ☐ WEB ☐ PSYCHOLOGY TODAY ☐ CHURCH

REFERRAL FROM OTHER

CLIENT INFORMATION SHEET

Do you have any medical conditions? Y ◉ N ○

If yes, describe:

Do you currently take any prescribed medications?

Name / Dosage (how long, if known) Purpose: Prescribed by:

Have you previously received counseling?

If yes, with whom did you meet?

When?

Does your family have a history of drug or alcohol problems?

Do you currently use alcohol?

Do you currently use illegal drugs or illegal substances?

Have you ever been a victim of physical abuse?

Have you ever been a victim of emotional or verbal abuse?

Have you ever been a victim of sexual abuse or assault?

Does your family have a history of mental health problems?

Have you ever been in legal trouble?

Have you ever attempted suicide?

If yes, approximately when was this attempt made?

Are you currently experiencing suicidal thoughts or feelings?

Do you currently have a suicide plan?

CLIENT INFORMATION SHEET

Please check all of the feelings below that you are experiencing or that have influenced your decision to seek counseling:

- ☐ Helplessness
- ☐ Fear
- ☐ Depression
- ☐ Doubt
- ☐ Shame
- ☐ Mood Shifts
- ☐ Anger
- ☐ Inferiority
- ☐ Guilt
- ☐ Insecurity
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Loneliness
- ☐ Confusion
- ☐ Sadness
- ☐ Lack of Motivation
- ☐ Stress
- ☐ Unloved
- ☐ Anxiety
- ☐ Irritation
- ☐ Out of Control
- ☐ Low Self Esteem
- ☐ Extreme Excitement/ Enthusiasm
- Other:

Please check all of the thoughts below that you are experiencing or that have influenced your decision to seek counseling:

- ☐ Confused
- ☐ Disorganized
- ☐ Obsessive
- ☐ Repetitive
- ☐ Racing
- ☐ Frightening
- ☐ Distracted
- ☐ Paranoid
- ☐ Homicidal
- ☐ Suicidal
- ☐ Perfectionistic
- Other:

Please check all of the physical symptoms below that you are experiencing:

- ☐ Insomnia
- ☐ Dizziness/ Lightheadedness
- ☐ Weight Gain
- ☐ Numbness/ Tingling
- ☐ Weight Loss
- ☐ Vomiting
- ☐ Muscle Tension
- ☐ Racing Heart
- ☐ Nausea
- ☐ Dry Mouth
- ☐ Fatigue
- ☐ Excessive Sleep
- ☐ Headaches
- ☐ Memory Loss
- ☐ Tightness in Chest
- ☐ Loss of Menstrual Cycle
- ☐ Eating Problems
- Other: