

Willow Oaks Counseling * Dannel Wissler, LPC
1018 North Christian Street, Lancaster PA 17602
717-723-9434

CLIENT CONTACT & INFORMATION SHEET

Name: _____ Birth Date: ____/____/____ Age: _____

Address: _____

Home Phone: _____ Cell/Other Phone: _____

May We Leave a Message? Yes/No

E-mail:

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: (____) ____ - ____

How would you describe the reason you are here?

Personal History:

Have you ever participated in therapy/mental health services before? Y* _____ N _____

*If so, where have you received clinical services?

Date:	Length of Treatment:	Hospital/Agency:	Type of Clinical Service:
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any changes you have noticed recently in your:

Sleeping habits: _____ How many hours/night? _____ Energy Level: _____

Eating habits: _____ Appetite? _____ Activity Level: _____

Sexual Interest: _____ Thoughts: _____

Please describe your mood: _____ Do you have current thoughts of suicide? Y _____ N _____

MEDICAL HISTORY:

Who is your Doctor or Primary Care Practitioner? _____

Have you ever had medical problems? Please Describe: _____

Do you have any known Allergies or Drug Sensitivities?

Current Medications and dosage: _____

SUBSTANCE ABUSE HISTORY:

Describe current alcohol consumption; how often do you drink and how much do you usually drink each time?

Do you use any drugs, not prescribed by your doctor?

If so, what, how often and how much? _____

Do you ever take more medication than your doctor has prescribed? Y _____ N _____

Have alcohol or drugs ever caused a problem for you?

FAMILY SYSTEM REVIEW:

Mother: Living/Deceased

Father: Living/Deceased

Siblings: (List in order of age, including yourself)

Name (Brother/Sister): Age:

Significant Other/Partner Name: _____

CHILDREN:

Name: _____ Age: _____ Do your children live with you? Y _____ N _____

Name: _____ Age: _____ If not, where do they live? _____

Name: _____ Age: _____

Has anyone in your family ever received care for mental health concerns or substance abuse? Y _____ N _____

Relationship: _____ Problem: _____

Relationship: _____ Problem: _____

Has anyone in your family ever committed suicide? Y _____ N _____

EDUCATION REVIEW:

Highest grade completed in school: _____

What problems, if any, did you have in school? _____

EMPLOYMENT HISTORY:

Current place of employment: _____ How long? _____

Type of work: _____

LEGAL HISTORY:

Have you ever had legal problems? Describe:

OTHER SIGNIFICANT INFORMATION:

Signature: _____ Date: _____