Understand. Heal. Grow.

DANNEL WISSLER, LPC
1018 NORTH CHRISTIAN STREET, LANCASTER PA 17602

CLIENT CONTACT & INFORMATION SHEET

NAME:_________________________________ BIRTHDATE: ____ /____ /____ AGE:______

ADDRESS _________________________________ ________________________
STREET TOWN

__________ __________
STATE ZIP CODE

HOME PHONE (____) ______ - ________ CELL PHONE (____) ______ - ________

CIRCLE PRIMARY CONTACT NUMBER?

home phone / cell phone

MAY A MESSAGE BE LEFT?

yes/no

EMAIL ADDRESS _________________________________

PLEASE NOTE EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION.

EMERGENCY CONTACT INFORMATION

Name _________________________________ Relationship ________________________

Phone Number (____) ______ - ________

PERSONAL HISTORY

What brought you to counseling?

____

____

____

HAVE YOU EVER PARTICIPATED IN THERAPY/MENTAL HEALTH SERVICES BEFORE?

yes/no

IF SO, WHERE HAVE YOU RECEIVED SERVICES?

DATE	LENGTH OF TREATMENT	HOSPITAL/AGENCY	TYPE OF CLINICAL SERVICE
__________	___________________	___________________	___________________
__________	___________________	___________________	___________________
__________	___________________	___________________	___________________

PLEASE DESCRIBE THE FOLLOWING

Sleeping habits: ______________________ Hours/Night __________

Eating habits: ___________________________

Sexual Interest: ___________________________

Describe your mood: ___________________________

Appetite: low med high

Energy level low med high

Activity Level: low med high

Current thoughts of suicide: yes/no

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 sensitivites?

____

Current medications and dosage: ________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

SUBSTANCE ABUSE HISTORY:

How often do you drink and how much do you usually drink each time? ___________________________

Do you use any drugs, not prescribed by your doctor? yes/no

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

Do you ever take more medication than your doctor has prescribed? yes/no

Have alcohol or drugs ever caused a problem for you? yes/no

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? yes/no

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? yes/no

Relationship:__________________________ Problem:__________________________

Relationship:__________________________ Problem:__________________________

Has anyone in your family ever committed suicide? yes/no

EDUCATION REVIEW:

Highest grade completed in school: _________________

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

EMPLOYMENT REVIEW:

Current place of employment: ___________________________________ How long? _________________

Type of work ____

LEGAL HISTORY REVIEW:

Have you ever had legal problems? Describe:

____

MILITARY SERVICE:

Have you served or are you currently serving in the military? yes / no

Year(s)? _________________ Branch(s)? _________________

Are you a War Veteran? yes / no

Year(s)? _________________ Branch(s)? _________________

Are you a Combat Veteran? yes /no

Year(s)? _________________ Conflict(s)? _________________

OTHER SIGNIFICANT INFORMATION:

____

____

____

Signature: ____ Date: _________________