TRUE NORTH
Counseling & Wellness

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Licensed Professional Counselor
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Client Information Sheet

Name: _____ Date: _____
Address: _____City: _____ State: _____ Zip: _____
Phone(s): _____ Birth Date: _____
May we contact you if needed at this address and number(s)? Yes_____ No _____
What is the main reason you have come here today?
_____
_____

Are you experiencing any of these symptoms? Please check mark.

Depressed	Anxious	Mood Swings	Loss of Interests
Low Energy/Tired	Restless/On Edge	Overly Emotional	Loss of Motivation
Difficulty Concentrating	Irritable/Angry	Under Emotional	Loss of Memory
Difficulty with Decisions	Worried	Guilt	Recurrent Memories
Low Self-Esteem	Over/Under Sleep	Resentful	Racing Thoughts
Hopelessness	Over/Under Eat	Rejected	Withdrawn
Helplessness	Crying Spells	Fearful	Sad

Is there other information you would like to share?
_____
_____
_____

Are you involved in any legal issues? Yes _____ No _____
Are you thinking of suicide, or in any way hurting yourself for another? Yes _____ No _____
Do you think alcohol, drugs or other types of addiction may need to be discussed? Yes _____ No_____
Do you have any physical difficulties that may influence therapy? Yes _____ No_____
Primary Physician/Psychiatrist: _____ Clinic: _____
Address: _____Phone: _____
Medications: _____
Previous Therapist/Counselor: _____Clinic: _____
Address: _____Phone: _____
Are we billing your EAP or insurance? Can we make a copy of your insurance card? _____
Primary Insured's Name: _____ Birth Date: _____
Address: _____Phone: _____
Primary Insured's ID number: _____Employer: _____
Insurance Plan: _____ Group Number: _____
May we have permission to contact your EAP or Insurance Company?

Authorized Signature: _____ Date: _____

Thank You