

BRIGHT HOPE

Christian Counseling Center, PLLC

Serving Individual Adult, Adolescent, Children and Couples

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CLIENT INFORMATION - ADULT

Client First Name: _____ Client Last Name: _____

Date of Birth: _____ Gender: _____ Race/Ethnicity: W H NA AA A

Age: _____ Weight: _____ Height: _____ Eye color: _____

Nationality: _____ Primary Language: _____ Interpreter Needed: Y N Unsure

Living Situation: Home / Homeless / Shelter / Foster Home / Group Home / Nursing Home / Other: _____

Home address 1: _____

Home address 2: _____

Employment: FT PT Unemployed SSDI Retired Current Place of Employment: _____

Marital Status: Single Married Divorced Widowed

of dependents & age: _____

Emergency Contact (Name, Phone number & relationship to client):

How were you referred to Bright Hope Christian Counseling Center: _____

Personal Information:

Briefly describe your current need to see a mental/behavioral health therapist:

Trauma / Abuse Intimate Partner Violence Information:

- Have you ever experienced physical neglect? YES NO UNSURE
- Have you ever experienced physical abuse? YES NO UNSURE
- Have you ever experienced verbal abuse? YES NO UNSURE
- Have you ever experienced emotional neglect/abuse? YES NO UNSURE
- Have you ever experienced sexual molestation, sodomy, rape? YES NO UNSURE
- Have you ever experienced elder neglect/abuse? YES NO UNSURE
- Have you ever been in an intimate partner violence relationship? YES NO UNSURE

Self-harm, suicidal & homicidal Information:

- Do you currently have thoughts of hurting or harming yourself? YES NO UNSURE
- Do you currently have thoughts of killing yourself? YES NO UNSURE
- Do you currently have thoughts of killing someone else? YES NO UNSURE

Family Psychiatric (mental health diagnoses) History:

Father:

Mother:

Siblings:

Extended Paternal Family:

Extended Maternal Family:

Medical Information:

Primary Care Physician: _____, MD / DO / PA / FNP / FNP-C

Practice Name and Location: _____

Serious Head Injury: Yes / No / Unsure

Allergies:

Non-Psychiatric Surgeries / Hospitalizations & year:

Illnesses / Conditions:

Headaches Dizziness Fatigue Seizures Eating Disorder Cancer Diabetes Hearing/Vision Problems

Problems Sleeping: falling asleep / staying asleep / frequent wakings Immune System Problems Heart Condition

Kidney Disease Liver Disease Lung Disease TB Symptoms/Diagnosis Stomach Disease/Ulcer/Ache/Pain

Other Important Medical Conditions:

Current Medications (Name, Dosage, Prescriber, Over-the-counter, Response to Medications) :

Substance Use / Abuse & Treatment Information:

Tobacco use

First used: Age ____ years old Never smoked Former Smoker Smoke Daily Smoke Occasionally

Smokeless Tobacco Only Vaping daily / occasionally Other:

Withdrawal / Tolerance level / symptoms:

Alcohol use

First used: Age ____ years old Never drank Former Drinker Drink Daily Drink Occasionally

Quantity consumed:

Last Date of Use:

Withdrawal / Tolerance level / symptoms:

Illegal drugs use / abuse: Yes / No / unsure Names & year:

Misused legal substance (prescription pills): Yes / No / unsure Names & year:

Significant loss / consequences / outcomes related to substance use / abuse:

Past / current substance abuse treatment / treatment recommended / prompted by criminal justice system or juvenile court:

Treatment History / Outcome:

Legal Information:

Have you ever been: Arrested Incarcerated Sentenced DUI occurrences Litigation Other:

Have you been arrested in the past 30 days: Yes / No / unsure

Details of your recent police arrest(s) / encounters :

Current Legal Information: Probation Protective Order Custody Dispute Juvenile Court Jurisdiction Parole

Foster Care Divorce Community Placement Civil Stalking Injunction Secure Facility

Other:

Civil Commitment (Court-ordered Psychiatric Treatment): Yes / No / unsure / Unknown

Details of civil commitment:

Development Milestones : Normal / Advanced / Delayed

Nursing Crawling Walking Climbing Running Skipping Talking Potty-Training Coloring Writing Reading

Other:

Education Information:

Education Level:

Learning Disability Needs:

Disciplinary Issues:

Acknowledgment & Signature:

I have read and agreed to the terms outlined in this document, CLIENT INFORMATION – ADULT. I acknowledge that I am the Client, or a legal representative of the client. I agree that my e-signature below is a legally binding equivalent to my handwritten signature.

Client Name (Print): _____

Client Signature: _____

Today's Date: _____