Salus Counseling
1655 W. Fairview Ave, Suite 115
Boise, Idaho 83702
Salus Messaging: 208-297-3197
Office Staff: (208) 515-7661
www.saluscounseling.com

CLIENT INFORMATION

Please answer all information as completely as possible. Information will be managed as protected health information. If you need assistance, please ask. Your Counselor will review this information with you.

Client Name: ______________________________ Date: ____________
First Name Last Name

Date of Birth: ____________ Age: ____ Race/Culture: ____________ Gender: ☐ Male ☐ Female

Address: ____
Street City State Zip Code

Home Phone # ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email: ____________________

- May we leave a message and appointment reminders? ☐ **YES** ☐ **NO**
- Check your preference: ☐ **Cell** ☐ **Home** ☐ **Work** ☐ **Email**

Marital Information: ☐ Single ☐ Married ☐ Living with a significant other ☐ Divorced ☐ Widowed

List any Medical Condition: ____

List Current Psychiatric Diagnosis, if any: ____________________________

____

Current Medications: ____

____

____

Primary Care Physician: ____________________ Number: ____________________

Emergency Contact: ____________________ Relation: ____________ Number: ____________

In the case of an emergency, I authorize my counselor to contact my emergency contact: ____________(initial)

Parent/Guardian: ____________________ Relation: ____________ Number: ____________

Parent/Guardian: ____________________ Relation: ____________ Number: ____________

Treatment History:

Counseling Services: Inpatient (dates) ____________ Out Patient (dates): ____________

What was helpful about your experience?: ________________________________

Psychiatric Services (dates) ____________ Physician's Name ____________________

Drug/Alcohol Treatment (dates) ____________ Treatment Center ____________________

Hospitalization (dates)____________________ Facility ____________________

Have you or are you currently contemplating harming yourself? ☐ **YES** ☐ **NO**

Have you or are you currently contemplating ending your life? ☐ **YES** ☐ **NO**

Has anyone in your immediate family attempted or completed suicide? ☐ **YES** ☐ **NO**

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Client Concerns

What Brought you into treatment? ____

____

What are your expectations for treatment? ____

____

What would you like to see happen as a result of coming into counseling? _______________

____

Presenting Problems/ Feelings / Experiences - Check all that apply -
RATE each concern that applies to you: 1=mild, 2=moderate, 3=severe

___Aggressive Behavior	___Alcohol Abuse/ Dependency	___Anger	___Anxiety
___Change in Appetite	___Compulsions	___Cutting/Injuring	___Delusions
___ Depression	___ Easily Annoyed	___ Easily Distracted	___ Eating Disorder
___ Emotional Abuse	___ Excessive Worry	___ Family Issues	___ Fatigue
___ Fearful	___ Financial	___ Friendship	___ Grief/Loss
___ Guilt/Worthlessness	___ Hallucinations	___ Headaches	___Hearing Things
___ Hopeless	___ Impulsivity	___Insomnia	___Intimacy
___ Irritability	___ Life Decisions	___ Loss of Pleasure	___ Mania
___ Medical Condition	___ Mood Instability	___ Muscle Tension	___ Pain
___ Panic	___ Paranoia	___ Parenting	___ Physical Abuse
___ Poor Concentration	___ Racing Thoughts	___ Relationships	___ Restless
___ Sadness	___ School	___ Seeing Through on Tasks	___ Self-Destructive Behavior
___ Sex Compulsion	___ Sexual Abuse	___ Sexuality	___ Sleeping Too Little
___ Sleeping Too Much	___ Spirituality	___ Stomachaches	___ Stress
___ Substance Abuse/ Dependence	___ Suicidal Ideation	___ Tearful	___ Trauma
___ Uncertain	___ Work	___ Other	

What are the top three concerns? ____

Approximately, How long have these issues been a problem for you? ____________________

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Alcohol/Substance Abuse

Preferred Substance: ☐ Tobacco ☐ Alcohol ☐ Prescription ☐ Narcotics ☐ Other:_______________

Date of last use:_____________ Age use began:_____________How Often: ________________________________

Have you ever had any legal problems as a result of drug/substance use? ☐ **YES** ☐ **NO**

Explain: ____

Have you ever had any relational problems as a result of drug/substance use? ☐ **YES** ☐ **NO**

Explain: ____

Has your use/consumption ever become a problem? ☐ **YES** ☐ **NO**

Interest/Hobbies

Please list your hobbies or interests: ____

____

List any cultural activities that you participate in that you are a part of your social or cultural background? ________

____

Family

Please list the members of your family of origin and how you would describe your relationship with each member

Family Member	Age	State of Relationship (example: poor, good, easy, conflictual, distant, disconnected, dependent on them, controlling, abusive, avoidant, etc)

:____

____