CLIENT INFORMATION

Name:_____Date:_____

What name would you like me to use?_____

Date of Birth:_____ Age:____ DL: _____ SS: _____

Address:_____

Primary Phone: _____ May we leave a message? □_Yes □_No

Alternate Phone: _____ May we leave a message? □_Yes □_No

Emergency Contact/Phone #

_____

How were you referred to Sober Buddha Counseling?

_____

Who is your primary physician?

_____

Do you currently have any major medical/psychiatric problems I should know about?

_____

Do you currently take any psychoactive prescription drugs I should know about?

_____

May I contact your primary physician for health information? ? □_Yes □_No
(I need your signed consent first)

_____

Marital Status: (circle one)

Never Married Divorced Separated Domestic Partnership Widow/Widower

Describe level of satisfaction with any current relationship you are in.

_____

List any children/ages:

_____

Level of education completed: (circle highest applicable)

High school/GED Junior College Bachelor's Degree Master's Degree Doctorate
Professional License or Certificate (name) _____

Describe your current work situation, e.g., type of work, position, number of years in current job, and anything unusual about your job history. Are you satisfied in your current situation?

_____

_____

Do you have a spiritual practice or religion? If so, please state your religion; whether you attend a church, temple or mosque regularly; or anything else important about your beliefs.

_____

_____

What is your previous experience with clinical hypnosis and/or mindfulness meditation?

_____

Have you been in counseling before? If so, what worked and what didn't?

_____

_____

Name four therapy goals you want to accomplish with SoberBuddha.

_____ _____

_____ _____

Name any significant childhood trauma I should know about, e.g., death of a parent at a young age, divorce, abuse, addiction, mental illness, etc., any other trauma?

_____

_____

Are you aware of being emotionally, physically, or sexually abused? □ Yes □ No
Have you ever attempted suicide? □ Yes □ No

Year, circumstances? _____

Please describe use of alcohol or recreational drugs (type, how much, how frequently):

_____

_____

Have you had any health, occupational or relationship problems due to any substance use, abuse or dependence?

_____

Do you currently have any legal problems/concerns that I should know about?

_____

Family Mental Health History: In the section below, please identify whether there are any of the following issues and which family member(s) were effected:

Alcohol/Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obsessive/Compulsive Behavior	Yes/No	_____
Other Addictive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

Do you experience any of the following three times or more per week? Please circle.

Feelings of sadness	Crying	Lack of energy
Keyed up, can't stop	Sleep troubles	Over/under eating
Irritable	Worrying too much	Stressed
Feel empty	Relationship troubles	Sexual concerns

Circle any of these issues that apply to you right now.

* Inability to experience and accept whatever is happening in the present moment
* Thinking about past traumas over and over
* Want to show more empathy, compassion, kindness to myself and others
* Not having enough meditation, prayer and stress-reduction skills

Name special skills, talents you have, i.e. - play piano, artist. Do you actively participate?

_____

Describe your exercise habits.

_____

Describe your sleep habits, average hours per night, time to bed, time wake up, etc.

_____

Describe your nutritional habits.

_____

What do you think is missing in your life right now?

_____

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