ECFA COUNSELING CENTERS

CLIENT APPLICATION

This form must be completed by each client 14 years and older.
If the client is younger than 14, the parent or guardian should complete.

Date: _____

Client Name: _____ Birth Date: _____ Age: _____

Parent/Guardian Name: _____
(circle one)

Address: _____
street city state zip

Home Phone: (____) Work Phone: (____) e-mail: _____

Racial/Cultural/Ethnic Background: _____

Others involved in counseling with you:

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Others immediate family members NOT involved in counseling with you:

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Marital Status:

Single_____ Married_____ Co-habitating_____ Separated_____ Widowed _____
Date Date Date Date

Previous marriage/divorce dates: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Specify any other CURRENT mental health treatment (e.g. psychiatrist, substance abuse):

Name and location of this professional: _____

Specify any prescribed medications and the purpose: _____

Name and location of physician prescribing medications: _____

Specify date range and purpose for previous counseling: _____

Name and location of previous counselor: _____

Specify any medical conditions we should be aware of: _____

Name and location of physician treating condition(s): _____

Client Name _____ Date _____

Filled out by (if other than client) _____

CHECK **ANY** OF THE FOLLOWING THAT APPLY TO YOU **AT PRESENT**

____	Always tired	____	unable to experience peace or forgiveness
____	poor appetite	____	unresolved grief
____	trouble sleeping	____	confused about personal religious practice
____	loss of weight	____	crying spells
____	weight gain	____	unable to have fun
____	lack of energy	____	feeling easily hurt
____	fast heartbeat	____	lacking in confidence
____	frequent sweating	____	feeling grouchy
____	dizziness	____	depressed
____	shaky hands	____	feeling lonely
____	stomach trouble	____	not enjoying things
____	feeling tense	____	feeling inferior
____	cold feet and hands	____	no one understands me
____	diarrhea	____	worried about health
____	constipation	____	can't concentrate
____	muscles twitching or jumping	____	can't "get going"
____	nausea or vomiting	____	feeling angry
____	headaches	____	don't like being alone
____	fainting spells	____	always worried
____	poor physical health	____	nightmares
____	full of energy	____	feeling panicky
____	financial problems	____	can't make decisions
____	marital problems	____	can't make friends
____	difficulties at work	____	unable to relax
____	excessive drinking	____	feeling fearful
____	can't hold a job	____	abuse by others
____	excessive use of medication	____	overly sensitive
____	excessive use of drugs	____	anxious inside
____	problems with children	____	sexual problems
____	problems with parents	____	easily excited
____	fighting & quarreling	____	quick tempered
____	can't handle money	____	impatient with people
____	overly ambitious	____	easily angered
____	difficulties at school	____	very restless
____	problems with addictions	____	feel like hurting someone
____	loss of meaning of life	____	feel like smashing things
____	feelings of guilt	____	shy with people
____	unable to pray		