Ambassador for Christ Pastoral Care and Counseling
Client Data Form

21 Ambassador Drive,
Paradise, PA 17562
717.687.8564

First Name _____ Last Name: _____ Middle Name: _____ Date of birth_____

ADDRESS _____
Street City State Zip

Primary phone number: _____
Is it okay to leave a message at this number? Y / N

Secondary phone number: _____
Is it okay to leave a message at this number? Y / N

Email address: _____ Is it okay to email you? Y / N

Marital Status: __ Single __ Married __ Divorced __ Separated __ Widow/Widower

Person to contact in case of emergency: _____
Phone _____
Permission to contact if Client is suicidal or homicidal _____ (Client initials)

How did you learn about this counseling center (website, posters, Associate, friend, etc)?
_____

Description of current concerns:

1. Please describe why you decided to come to counseling:

2. How long has this been a significant concern for you?

3. How would you estimate the severity of this concern at this time?
   (place an x on the line)
   _____
   Mild Moderate Serious Severe

4. If applicable, please describe any incidents or problems that may have contributed to your current concerns (e.g. death of a loved one, problem with work or school, relationship ending, past trauma):

5. In the past, what has been helpful to you in dealing with difficulties?

6. Circle all of the following problems/symptoms you are currently experiencing:

Depressed mood	Anxiety	Compulsive behaviors
Difficulty concentrating	Mood swings	Outbursts of temper
Restlessness	Fatigue	Sleep disturbances
Aggressive behavior	Flashbacks	Cutting or self-injury
Distrust	Chronic pain	History of sexual abuse
Nightmares	Alcohol/drug dependency	Suicidal thoughts
Obsessive thoughts	Parenting difficulties	Disordered eating (over-eating, purging, etc)
Sexual issues	Low motivation	
Crying	Social withdrawal	
Easily distracted	Fears/Phobias	

Other symptoms:

If depressed mood, please describe:

Family Information

Please list the members of your household (currently living with you):

Name Age Relationship to you (e.g. son, spouse)

Among your friends and family, on whom do you count for support?

Any marital or family information that would be helpful to explain?

Physical Health History

I think my general health is: good_____ average_____ poor_____

Are you presently under medical care or are you taking any prescribed medications? If yes, please list:

Any other physical health history that would be important to mention?

Mental Health History

Are you in treatment with another counselor at this time? __ Yes __ No

If yes, with whom? _____

Reason(s):

Have you (or your family members) ever been involved in counseling? __ Yes __ No

If yes, with whom? _____ When? _____

Reason(s):

Any other mental health history you believe is important to mention?

Spiritual History
Do you attend a church? Y / N Name of church: _____

How would you describe your relationship with God?

How have your faith experiences helped or hindered your ability to deal with your struggles?

Client Notification of Privacy Rights
The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy Law", HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care. While we do not provide mental health counseling, we will comply with HIPAA regulations regarding the protection of your records. Your signature below indicates that you understand this Client Notification of Privacy Rights document. If you have any questions about any of the matters discussed above, please do not hesitate to ask us for further clarification.

I have read and understood the Pastoral Care and Counseling Informed Consent Form, including the Client Notification of Privacy Rights section.

Name (Print): _____

Signature of Client or Guardian: _____ Date: _____