HIGGINS COUNSELING SERVICES

CLIENT INFORMATION FORM

2500 Quantum Lakes Dr,
Suite 203,
Boynton Beach, FL 33426

Office: (561) 853-1374 Cell: (561) 247-3694
Email: higginscounselingservices@gmail.com
Web: higginscounselingservices.com

CONFIDENTIAL INTAKE INFORMATION

Client Name:_____ Age:_____ Gender:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

Home Phone:_____ Cell Phone:_____

Employer:_____Email:_____

Address of Residence:

_____

_____

County of Residence:_____

Is Client the Responsible Party? (circle) yes no

Name of Responsible Party (if different than client):_____

Relationship to Client:_____

Client/Responsible Party Billing Address:_____

_____

Marital Status: (circle) Single Married Cohabitating Divorced Re-Married Other

Name of Spouse or Partner:_____

Spouse or Partner's Address:_____

_____

Phone:_____ Email:_____Occupation:_____

SS#:_____ DOB:_____

Names of Children DOB Living in the Home?

_____

_____

_____

_____

_____

PLEASE COMPLETE THIS PAGE IF CLIENT IS UNDER 18

Father's Name: _____ DOB:_____ SSN#:_____

Father's Address (If different than client):_____

_____

Mother's Name: _____ DOB:_____ SSN#:_____

_____

Client Initial

Mother's Address (If different than client):_____

_____

Parents Relationship: (circle) Married Divorced Separated Never Married

Client's Legal Guardian(s): _____

Provide contact information here if not listed elsewhere on form:

Address:_____

SSN#: _____DOB:_____Phone:_____

If parents are not together or child is currently in foster care or adopted, who has the right to make medical decisions?

_____

_____

_____

Please provide therapist with custody and other legal paperwork needed to ensure therapist has permission by guardians to see client. Without necessary paperwork, therapist may be unable to see the client.

Please check all that apply to you and may be a focus of treatment:

- ☐ Anxiety
- ☐ Depression
- ☐ Relationships and Boundary Issues
- ☐ Lying/Manipulation
- ☐ Academic Problems (Children and Adolescents)
- ☐ Behavioral Problems (Children and Adolescents)
- ☐ Marital Concerns
- ☐ Dealing with Divorce
- ☐ Parenting Concerns
- ☐ Risk of harming yourself or others
- ☐ Anger Issues
- ☐ Developmental Problems
- ☐ Sleep Problems
- ☐ Confidence/Self-Esteem Issues
- ☐ Feeling Isolated From Others
- ☐ Afraid or Suspicious
- ☐ Losing Track of Time
- ☐ Nightmares
- ☐ Intrusive Memories
- ☐ Sexual Issues
- ☐ Stress Management
- ☐ Traumatic Experiences
- ☐ Sexual Abuse
- ☐ Physical Abuse (Including Domestic Violence)
- ☐ Emotional/Mental Abuse
- ☐ Loss of Control
- ☐ Destructive Life Patterns
- ☐ Substance Abuse (Past and/or Present)
- ☐ Family of Origin Issues
- ☐ Career Changes
- ☐ Financial Problems
- ☐ Specific Fears or Panic
- ☐ Memory Problems
- ☐ Other:_____

_____

_____
Client Initial

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about Higgins Counseling Services?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

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If yes, was your experience positive or negative and why?

_____

_____

_____

Religious History (Optional)

In what religious faith were you raised? _____

Present affiliation or name of church you attend? _____

Have you accepted Jesus as your Lord and Savior? Yes _____ No _____ Unsure _____

If yes, when did you accept Him? _____

Have your religious experiences and training helped or hurt your ability to deal with your

struggles?_____

_____

_____

How often do you read your Bible? _____

Do you have a regular time to pray? _____

Have you had any unusual “religious experiences”? ____ Yes _____ No If yes, please explain:

_____

_____

Background Information

LEGAL: Current _____ Previous _____ N/A _____

Charges _____ Probation? _____

Court district _____

_____
Client Initial

EDUCATION:

Highest – grade achieved: _____

Name of College or Vocational school: _____

Year of Graduation _____ Graduate school _____

MILITARY:

Dates of service _____ Branch _____ Rank _____

Type of discharge _____

How were your relationships with peers? _____

With supervisors? _____

WORK HISTORY

Are you satisfied with your present occupation? _____

How long have you been with your present company? _____

Are you satisfied with your present income level? _____

DAILY ROUTINE

How is your appetite? _____ Any changes in the last six months? _____

Recent weight loss or gain? _____

How well do you sleep? _____Any changes in the last six months _____

Fall asleep OK? _____ Stay asleep? _____

Describe your exercise habits.

_____

_____
Client Initial