

Therapist \_\_\_\_\_  
**Champions Christian Counseling & Educational Services**  
333 S. Cherry Street  
Tomball, Texas 77375

*Client Application Form*  
Date \_\_\_\_\_

Where did you hear about Champions Christian Counseling Services?  
\_\_\_\_yellow pages\_\_\_\_signs\_\_\_\_drive by\_\_\_\_friend\_\_\_\_other\_\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zipcode \_\_\_\_\_ Status: \_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Divorced  
Phone H. \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Children Names \_\_\_\_\_ Ages \_\_\_\_\_  
Children Names \_\_\_\_\_ Ages \_\_\_\_\_  
Children Names \_\_\_\_\_ Ages \_\_\_\_\_  
Children Names \_\_\_\_\_ Ages \_\_\_\_\_

Are you taking any kind of medication? \_\_\_\_yes \_\_\_\_no. List medications and amounts :  
\_\_\_\_\_

Have you ever been in counseling before? \_\_\_\_\_  
If yes for what reason? \_\_\_\_\_

**Emergency Contact: Who should be contacted in case of an emergency?**  
Name \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # H. \_\_\_\_\_ W. \_\_\_\_\_ Cell \_\_\_\_\_

**Family Physician:**  
Dr. Name \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Phone** \_\_\_\_\_

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**Reason for Counseling:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent for Services:**  
I \_\_\_\_\_, Consent to Treatment for psychological and  
behavioral services at Champions Christian Counseling Services.  
Client Name \_\_\_\_\_ Signature \_\_\_\_\_

## CLIENT HISTORY

Please check any of the following that apply:

### Symptoms

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Depressed                             | <input type="checkbox"/> Racing/Confused thoughts     | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Anxious                               | <input type="checkbox"/> Obsessive thoughts/behaviors | <input type="checkbox"/> Light-headed              |
| <input type="checkbox"/> Socially unacceptable conduct         | <input type="checkbox"/> Thoughts of death/suicide    | <input type="checkbox"/> Shortness of breath       |
| <input type="checkbox"/> Problems at work                      | <input type="checkbox"/> Crying spells                | <input type="checkbox"/> Trembling                 |
| <input type="checkbox"/> Anger                                 | <input type="checkbox"/> Withdrawn                    | <input type="checkbox"/> Sexual impairment         |
| <input type="checkbox"/> Rage                                  | <input type="checkbox"/> Increased appetite           | <input type="checkbox"/> Substance abuse           |
| <input type="checkbox"/> Legal problems                        | <input type="checkbox"/> Decreased appetite           | <input type="checkbox"/> Other addictive behaviors |
| <input type="checkbox"/> Irritable                             | <input type="checkbox"/> Difficulty sleeping          | <input type="checkbox"/> Poor impulse control      |
| <input type="checkbox"/> Fearful                               | <input type="checkbox"/> Nightmares                   | <input type="checkbox"/> Abuse survivor            |
| <input type="checkbox"/> Frustrated                            | <input type="checkbox"/> Increased sleeping           | <input type="checkbox"/> Eating disorder           |
| <input type="checkbox"/> Fatigued                              | <input type="checkbox"/> Low energy                   | <input type="checkbox"/> Hearing voices            |
| <input type="checkbox"/> Feeling worthless                     | <input type="checkbox"/> Distracted                   | <input type="checkbox"/> Visual Hallucinations     |
| <input type="checkbox"/> Feeling guilty                        | <input type="checkbox"/> Talkative                    | <input type="checkbox"/> Diabetes/Hypoglycemia     |
| <input type="checkbox"/> Problems with concentration/attention | <input type="checkbox"/> Restless                     | <input type="checkbox"/> Thyroid problems          |
| <input type="checkbox"/> Communication problems                | <input type="checkbox"/> Relationship difficulties    | <input type="checkbox"/> High blood pressure       |
|  | <input type="checkbox"/> Heart palpitations           | <input type="checkbox"/> Seizures                  |
|  | <input type="checkbox"/> Excessive sweating           | Other (explain)                                    |
|  | <input type="checkbox"/> Nausea                       | _____  |

**Family History:** (Describe current living situation. i.e. who lives with you and some of the circumstances past and present.)

**Educational/Work History:** (Include highest grade completed, types of grades, vocational training, types of jobs held, current source of income, and any history of military duty.)

**Alcohol and Drug History:** (Include quantity and frequency, past and present, problems because of drinking/drug use, attempts to stop.)