

Counselor: _____

Champions Christian Counseling Center
333 S Cherry Street
Tomball TX 77375
281-357-4111

Client Information Form

Date: _____

DX Code: _____

Where did you hear about Champions Christian Counseling Services?

____ Yellow Pages ____ Signs ____ Drive By ____ Friends Other _____

Client Name: _____ SS# _____ DOB: _____

Person Financially Responsible: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Marital Status: __ Married __ Single __ Divorced

Phone: (HM) _____ (WK) _____ (Cell) _____

Email Address: _____

Children Names: _____ Age: ____ Children Names: _____ Age: ____

Children Names: _____ Age: ____ Children Names: _____ Age: ____

Are you taking any kind of medication? __ Yes __ No List medications and amounts: _____

Emergency Contact: Who should be contacted in case of an emergency?

Name: _____ Relationship: _____

Address: _____

Phone: (Hm) _____ (Wk) _____ (Cell) _____

Family Physician:

Name: _____ Phone # _____

Insurance:

Name of Insured: _____ Insurance Carrier: _____

Employer: _____

Carrier Phone # _____ Insured's SS# _____

Policy # _____ Group # _____

Reason for Counseling: _____

Consent for Services:

I, _____, consent to treatment for psychological and counseling services at Champions Christian Counseling Center, LLC.

Client Name: _____ Signature: _____

**Champions Christian Counseling Center
Client Application Form Page 2**

CLIENT HISTORY

Please check any of the following symptoms that apply:

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 Withdrawn | 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

Family History: (Describe current living situations, 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.)

Other Relevant Information:
