Shelly L. Peed, PhD, LPC, NCC, CCH, DCC All Clear Counseling, LLC 914 S. Leighton Ave. Anniston, AL 36207

Client Information Form

Phone (home) Phone (work) Phone to leave message for you Email: If you need any more space for any of the questions, please use the back of the sheet. While this is a please understand that the more information you share the better informed I become in helping you. I any questions, please ask at our initial appointment. FAMILY INFORMATION RELATIONSHIP NAME AGE LIVING? LIVING WITH YOU? Mother Spouse Child Chil	Client's name	Date				
Address City State Zip Phone (home) Phone (home) Phone (work) Phone to leave message for you Email:	Last	First	Middle			
Address	Gender: FM_	Date of Bi	irth	Age		
Phone (home)Phone (work)	Address		City	S	tateZip	
Email:	Phone (home)	Pho	one (work)			
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Spouse Child Child Child Child Child Child Child Child (Brothers, Sisters, Grandparents, Step-relatives, Half-relatives) RELATIONSHIP NAME AGE LIVING? LIVING WITH YOU? Marital Status (More than one answer may apply) Single Legally married How long?) Separated (How long?) Divorced (How long?) Annulment Divorce in progress						
Child	Spouse					
Child (Brothers, Sisters, Grandparents, Step-relatives, Half-relatives) RELATIONSHIP NAME AGE LIVING? LIVING WITH YOU? Marital Status (More than one answer may apply) Single Legally married How long?) Separated (How long?) Divorced (How long?) Annulment Divorce in progress	Child					
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Divorced (How long?) Annulment Divorce in progress	Marital Status (Mo	re than one answer m	nay apply)		1	
	Single Legally	married How lo	ong?) Separate	d (Ho	w long?)	
Inmarried living together (How long?) Widowed (How long?)	Divorced (Ho	w long?) Annulment_	Divorce in pro	ogress		
	Unmarried living to	gether (How long)	?) Widowed	(How lone	g?)	

Parents legally married			
arents regarry married			
Parents have ever been separated	Mother remarried: No. of times		
Parents ever divorced	Father remarried: No. of times		
	Education		
Highest degree earned:			
Major: Minor:			
	Development		
Are there special unusual or traumatic circum	nstances that affected your development? Yes No		
•	instances that affected your development:1esNo		
If 1 DB, pieuse describe			
Has there been history of child abuse?Ye	es No		
If YES, which type(s)?SexualPhysic.			
	lequate nutritionOther (please specify)		
Comments re: childhood development			
	Social Relationships		
Check how you generally get along with other	voidantFight/argue oftenFollowerShy/WithdrawnSubmissive		
Check how you generally get along with otherAffectionateAggressiveAvFriendlyLeaderOutgoing	r people: (check all that apply) voidantFight/argue oftenFollowerShy/WithdrawnSubmissive		
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Check how you generally get along with other AffectionateAggressiveAvFriendlyLeaderOutgoingOther (please specify) Sexual Orientation Sexual Dysfunction?YesNo If Y How important to you are spiritual matters?	r people: (check all that apply) voidantFight/argue oftenFollowerShy/WithdrawnSubmissive Comments:		
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		Employment	
Currently employed?Y	YesNo Emplo	oyer	
Current position			
		Military	
Military Experience?Y	YesNo	Combat Experience	ce?YesNo
Branch of Service			
Duty Station(s)			
Current Military Status:	ActiveRetir	redNeservesNe	at'l GuardDischarged
If Discharged:			
Rank at time of Disc	charge		
Type of Discharge_			
	Leis	sure/Recreational	
Describe special areas of int church activities, etc.)			physical fitness, outdoor activities,
		Medications	
Name of Medication	Dosage	Purpose	Prescribing Doctor

Medical/Physical Health

Are you currently experiencing any of the following?

AIDS	Diarrhea	Hepatitis
Alcoholism	Difficulty breathing	High blood pressure
Abdominal pain	Difficulty handling money	Kidney problems
Abortion	Dizziness	Loss of pleasure or enjoyment
Allergies	Drug abuse	Low energy
Anemia	Ear infections	Mononucleosis
Appendicitis	Eating problems	Menstrual pain
Arthritis	Epilepsy	Neurological disorder
Asthma	Fainting	Nausea
Anxiety	Fears	Nightmares
Bed Wetting	Feeling angry/resentful	Panic
Cancer	Feel life is not worthwhile	Poor appetite
Chest pain	Feeling sad or hopeless	Problems with sex
Chronic pain	Feeling tired or discouraged	Thoughts of suicide
Cold/cough	Fighting/arguments in your family	Using drug
Constipation	Forgetting things	Using alcohol
Dental problems	Having frightening thoughts	
Desire to end your life	Headaches	
Diabetes	Heart racing	

Family Health History

Please describe any mental health issues (if any) experienced by family members of relatives: