AYESHA G. SHENK, LMHC
Counseling & Consulting

Client Information:

NAME: _____ **DATE:** _____ **DOB:** _____

PHONE: Cell _____ **Home** _____ **Work** _____

ADDRESS: _____

_____ **EMAIL:** _____

May I contact you by Phone? Cell ☐ **Home** ☐ **Work** ☐ **Email** ☐

Education: _____ Religious Affiliation: _____

Occupation: _____ Marital Status: _____

Employer: _____ Referred by: _____

Have you received counseling before? Yes ☐ No ☐

If yes, with whom? _____ when? _____

What is the problem/concern that brought you to counseling?

Please check any of the following symptoms/ issues that concern you.

	EMOTIONAL/ BEHAVIORAL		HEALTH/ PHYSICAL		FAMILY/ INTERPERSONAL		PROFESSIONAL/ ACADEMIC
☐	Sadness	☐	Drug use	☐	Conflict with spouse/partner	☐	Procrastination
☐	Thoughts of suicide	☐	Alcohol use	☐	Divorce	☐	Concentration
☐	Hopelessness	☐	Smoking	☐	Conflict with parents/siblings	☐	Motivation
☐	Tension/anxiety	☐	Weight gain/loss	☐	Relationship conflict	☐	Time management
☐	Fears	☐	Insomnia	☐	Conflict with children	☐	Poor performance
☐	Loneliness	☐	Sleeping too much	☐	Dating/meeting people	☐	Perfectionism
☐	Crying	☐	Stomach trouble	☐	Sexual concerns	☐	Stress
☐	Fatigue	☐	Headaches	☐	Sexual orientation concerns	☐	Anxiety
☐	Emotional ups/downs	☐	Muscle tension	☐	Gender identity concerns	☐	Conflict with coworkers
☐	Anger	☐	Back pain	☐	Sexual Abuse	☐	Dissatisfaction
☐	Low self-esteem	☐	Tingling	☐	Family illness	☐	Worry about job security
☐	Overeating	☐	Numbness	☐	Death in the family	☐	Career change
☐	Lack of appetite	☐	Rapid heart beat	☐	Social isolation	☐	Unemployment
☐	Risk-taking	☐	Medical illness	☐	Assertiveness	☐	Loss of job
☐	Impulsivity	☐	Medication	☐	Shyness	☐	Financial concerns
☐	Other	☐	Other	☐	Other	☐	Other