



Ranch Hand Rescue

COUNSELING CENTER & ANIMAL SANCTUARY

Client Information Sheet- Please complete the **relevant** information

Client's name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

By entering your telephone contact information below, you are giving permission for me to leave messages on your voice mail in regards to your appointments and billing balances. You also acknowledge that you understand you may not be the only person to hear that message.

Home: () _____ Work: () _____

Cell: () _____ Email _____

Birth date: _____ Age: ____ Grade _____

Employer/School: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Ranch Hand Rescue's Counseling Center? _____

Emergency Contact: _____ Phone _____

Are you or your child currently seeing a therapist? _____

If so, please provide names and phone numbers: _____

List all therapists you/your child has seen, dates you saw them, and contact information:

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

List any medications you/your child are currently taking:

What kind of problem brings you to Ranch Hand Rescue's Counseling Center?

Please indicate with a **C** if you are having any of the following problems currently and a **P** if you've had the problem in the past:

_____ Sleep difficulties (too much, too little, trouble falling or staying asleep)

_____ Problems in school (behavior or learning) or work

_____ Change in appetite, weight loss, or weight gain

_____ Frequent crying

_____ Panic attacks or anxiety attacks

_____ Thoughts (or attempts) of killing or hurting myself

_____ Avoid doing things or being with people that I used to like

_____ Problems concentrating

_____ Periods of daily sadness lasting more than two weeks

_____ Can't stop remembering upsetting past events

_____ Difficulty controlling anger/temper tantrums/irritable

_____ Guilt or shame

_____ Bed wetting after being toilet trained

_____ Excessive worry

_____ Nightmares/flashbacks

_____ Throw up, use laxatives, or exercise excessively to lose weight

_____ Startle easily/hypervigilant

_____ Feel like I am an outsider /isolating myself from others

_____ Sexual behavior problems_____

_____ Frequent arguments with the people I live with

_____ Hear voices inside my head or see things that aren't there

_____ Physically injury myself

Other (please list):_____

Client or Parent of minor child

Date