RANCH HANDS RESCUE
Human & 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