Christine Ubben, M.A.
Licensed Professional Counselor
Licensed Associate Marriage & Family Therapist

Office:
14051 Burnhaven Drive, Suite 105
Burnsville, MN 55337-4400

Phone: 952-288-4091
Fax: 952-513-4813
Website: www.ubbencounseling.com
E-mail: christine@ubbencounseling.com

Client Information

Today's date: ________________

***Note**:* If you are returning client, please complete only the information that has changed since your last visit.

A. IDENTIFICATION

Your name: ____________________________________ Date of birth: ___________ Age: _______

Home street address: ____ Apt.: _________

City: ____ State: ________ Zip: _______________

Home/evening phone: ____________________________ Cell phone: _______________________

Work phone: _________________________________ Other phone: _______________________

Email address: ____

May I leave a brief message on your home phone? _________ Cell phone? ______ Work phone? ________

Please indicate any restrictions to calling you: ____

____

Emergency Contact: Name____

Address: ____

Phone Number(s): ______________________________ Relationship to you: ____________________

B. REFERRAL

How did you come across my name/services? _______________________________________

If you were referred to me, who referred you?

Name: ____ Phone: __________________

Address: ____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

C. PRIMARY CONCERN

Please describe the primary reason(s) for seeing me:____

____

____

D. MEDICAL CARE

From whom do you receive your medical care?

Clinic/doctor's name: ____Phone:______________

Address: ____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. RELATIONSHIPS/CHILDREN

Are you presently in a relationship or married? ❑Yes ❑No Name of partner/spouse:_____________

How long have you and your partner/spouse been together?_____________

List prior significant relationships:

Name of Prior Partner/Spouse	Length of relationship	Reason for Ending

Do you have children? ❑ Yes ❑ No If yes, please provide the following information:

Name (include last name if different from your own)	Age	Biological/Step/ Adopted/Other	From previous relationship? If yes, name of biological parent?	Does the child reside with you? If no, where?

F. CURRENT EMPLOYER

Employer: ____

Address: ____

G. PRIOR TREATMENT

1. Counseling:

Are you receiving or have you received counseling, psychological, psychiatric, drug or alcohol treatment before?

❑ Yes ❑ No If yes, please indicate:

Name and Address of Provider	Date	Reason for Services	Results from Services

If you received counseling in the past, what did you find helpful or not helpful in your counseling experience? ____

____

2. Prescribed Medication(s):

Are you taking or have you taken prescribed medications for psychiatric or emotional problems?

❑ Yes ❑ No If yes, please indicate:

Name and Address of Provider	Date	Prescription and Dosage	Reason for Rx	Results from taking Rx

H. STRESS

Please rate your current, overall level of stress:

1 2 3 4 5

Minimal Moderate Extreme

I. IMPACT OF PRESENTING CONCERN(S)

How do your presenting concerns impact the following areas of your life:

1. Your thoughts, emotions, behavior, and/or health:____

____

2. Relationships:____

____

3. Work :____

____

4. Extracurricular activities:____

____

5. Other:____

____

J. SUPPORT

How would you rate the network of support that is available to you at this time, i.e. family, friends, church, state assistance, nonprofit organizations?

1 2 3 4 5

None Some Sufficient

If you are receiving support, who is helping you and in what capacity are they helping (i.e. financial, emotional, work-related, childcare)? ____

____

If you would like additional support, what type of support would be helpful to you? ________________

____

K. RESULTS

What are the changes or improvements that you would like to see as a result of counseling?__________

____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.