DEMOGRAPHIC FORM

Last Name	First Name	M.I.	Date
Maiden or previous names		Date of Birth: _____ /_____ /_____	
Gender ___ Male ___ Female	Religion		
Name of person completing this form	Relationship to Client		

Client Contact (*Does client provide approval for ACC staff to identify themselves or leave a message?)*:

Personal Phone *YES / NO*	Work Phone *YES / NO*		
Email			
Street Address	City	State	Zip

Emergency Contact *(Must also complete a Release of Information form)*:

Name	Relationship
Personal Phone	Work Phone

Medical Decision-Making Authority for Minors *(Must also complete a Consent form)*:

Name	Relationship
Name	Relationship

	Ethnicity		Race *(select all that apply)*		Marital Status
	Hispanic or Latino		White / Caucasian		Never Married
	Not Hispanic or Latino		Native Hawaiian / Pacific Islander		Married
	Unknown		American Indian / Alaskan		Married, separated
	Decline to Specify		Asian		Widowed
			Black / African American		Divorced
			Declined to Specify		

Current Primary Role / Employment / School Status

	Employed (Full Time +35 hours/week)		Military		Volunteer
	Employed (Part Time ≤35 hours/week)		Unemployed		Homemaker
	Student		Disabled		Retired

Highest Education Level (completed)	Veteran Status
Current Employer	Experienced Trauma? *YES / NO*

DEMOGRAPHIC FORM CONTINUED

Disabilities *(choose all that apply)*

	None		Traumatic Brain Injury		Blind/Severe Vision Loss
	Learning Disability		Deaf/Severe Hearing Loss		Developmental Disability

What symptoms are you currently experiencing? *(Circle all that apply)*

	Difficulty Sleeping		Anger Management Problems		Thoughts of harming yourself
	Disturbing Thoughts		Drug / Alcohol Abuse		Thoughts of harming someone else
	Victim of Assault / Abuse		Addictive Behavior(s)		Anxious Thoughts
	Marital Conflict		Depressed Mood		Self-injury (cutting, reckless behavior)

What are your primary mental health concern(s)? ____

____

____

____

____

Existence of Current Mental Health Concern __ Longer than 1 year __One year or less

How many times have you received mental health treatment in the past? ____

What did you benefit from, or not benefit from, during previous therapeutic experiences? ____________

____

____

____

Other concerns / stressors you are currently experiencing? _________________________________

____

Referral Source:
How did you hear about Arukah Christian Counseling? ____