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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Please complete each section of this form with as much information as possible. All information on this form is strictly confidential and will become part of your file.* | | | | | | | | | | **Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **CLIENT’S INFORMATION** | | | | | | | | | | | |
| Name (Last, First, M.I.): | |  | | | | | | |  | **DOB** *(mm/dd/yy)***:** | |
| **Address:** | | | | | | | | | | **Soc. Sec. # - -** | |
| 🞎 Male 🞎 Female | |
| **If a minor, name of Parent(s)/Legal Guardian(s):** | | | | | | | | | | | |
| **Primary Phone:** | | | | | 🞎 Cell 🞎 Home 🞎 Work | | | | | May we leave a message? 🞎 Yes 🞎 No | |
| **Secondary Phone:** | | | | | 🞎 Cell 🞎 Home 🞎 Work | | | | | May we leave a message? 🞎 Yes 🞎 No | |
| **E-mail Address:** | | | | | | | | | | | |
| May we send e-mails regarding scheduling and basic information? | | | | 🞎 Yes 🞎 No | | | | May we send e-mails regarding therapy concerns? | | | 🞎 Yes 🞎 No |
| Marital status: 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | |
| **Employer:** | | | | | | | | **Occupation:** | | | |
|  | | | | | | | | | | | |
| **SPOUSE’S INFORMATION** | | | | | | | | | | | |
| *If you are seeking relational counseling, please use this section to list any other adult’s personal information that is attending sessions with you.*  *\*If seeking individual counseling, only provide the information marked with an asterisk (\*).* | | | | | | | | | | | |
| \*Name (Last, First, M.I.): | | | | | | | | | | **DOB** *(mm/dd/yy)***:** | |
| **\*Address** (*If different):* | | | | | | | | | | **Soc. Sec. # - -** | |
| 🞎 Male 🞎 Female | |
| **\*Primary Phone:** | | | | | 🞎 Cell 🞎 Home 🞎 Work | | | | | May we leave a message? 🞎 Yes 🞎 No | |
| **\*Secondary Phone:** | | | | | 🞎 Cell 🞎 Home 🞎 Work | | | | | May we leave a message? 🞎 Yes 🞎 No | |
| **E-mail Address:** | | | | | | | | | | | |
| May we send e-mails regarding scheduling and basic information? | | | 🞎 Yes 🞎 No | | | | | May we send e-mails regarding therapy concerns? | | | 🞎 Yes 🞎 No |
| **Marital status:** 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | |
| **Employer:** | | | | | | | | **Occupation:** | | | |
|  |  | | | | | | | | | | |
| **OTHER’S LIVING IN THE HOME** | | | | | | | | | | | |
| Name | | | | | | DOB | | | | Relation | |
| Name | | | | | | DOB | | | | Relation | |
| Name | | | | | | DOB | | | | Relation | |
| Name | | | | | | DOB | | | | Relation | |
|  | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | |
| **Emergency Contact:** | | | | | | | **Relationship to Client:** | | | | |
| **Primary Phone:** | | | | | | | **Secondary Phone:** | | | | |

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| *Physical problems/hospitalizations/surgeries* | *Date of procedure/diagnoses* |
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| PERSONAL HEALTH HISTORY | | |
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| PRIMARY CARE PHYSICIAN | | |
| Physician’s Name: | Phone: | |
| Address: | Date of last physical exam: | |
| Would you like for us to be in contact with your PCP? (release required) | 🞎 Yes 🞎 No |
| List any medical or physical problems, hospitalizations, and surgeries; include when they were diagnosed | | |

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| List all prescription and over-the-counter drugs you are taking: | | | | | | | | | | | | |
| *Medication* | | | *Dosage* | | | | *Date/age prescription began* | | | | | |
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| List any allergies to medications: | | | | | | | | | | | | |
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| HEALTH HABITS AND PERSONAL SAFETY | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| All Answers will be kept strictly confidential. | | | | | | | | | | | | |
| Exercise | 🞎 Sedentary (No exercise) | | | | | | | | | | | |
| 🞎 Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | | |
| 🞎 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | | |
| 🞎 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | | |
| Diet | Are you dieting? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | | 🞎 | Yes | 🞎 | No |
| # of meals you eat in an average day? | | | | | | | | | | | |
| Caffeine | 🞎 None | 🞎 Coffee | | 🞎 Tea | | 🞎 Cola | | | | | | |
| # of cups/cans per day? | | | | | | | | | | | |
| Alcohol | Do you drink alcohol? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, what kind? | | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | | |
| Age you first used alcohol: | | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you considered stopping? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever experienced blackouts? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Are you prone to “binge” drinking? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you drive after drinking? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever been arrested for driving under the influence (DUI)? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Is there a history of problems with alcohol use in your family? *(If yes, please list in family history section)* | | | | | | | | 🞎 | Yes | 🞎 | No |
| Tobacco | Do you use tobacco? | | | | | | | | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | | | 🞎 Chew - #/day | | 🞎 Pipe - #/day | | 🞎 Cigars - #/day | | | | |
| # of years: | If applicable, year quit: | | | | Age started: | | | | | | |
| Drugs | Do you currently use recreational or street drugs? If yes, please list: | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you currently use any prescription medications for other than their intended use or dosage? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Age first used drugs: | | | | Have you used in the past 3 months? | | | | | | | |
| Have you ever been arrested for or convicted of any drug related charges? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Is there a history of problems with drug use in your family? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Gambling | Have you ever gambled in a casino (including slot machines), bet on races, or sports, played cards for money or played the lottery? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, what kind? | | | | | | | | | | | |
| Sex | Are you sexually active? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have any concerns about your sexual activity, including sexual dysfunction, sexual orientation, birth control, or infertility? | | | | | | | | 🞎 | Yes | 🞎 | No |
| **Females Only:**  Have you had an abortion? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Personal Safety | Do you have a history of any type of abuse? Physical, sexual, emotional or neglect? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Is there any type of abuse happening in your life now? | | | | | | | | 🞎 | Yes | 🞎 | No |
| **Legal** | Are you currently or do you expect to be involved in any court-related matters? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, please list the type of court-related matter (custody, divorce, etc.): | | | | | | | | | | | |

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| FAMILY HEALTH HISTORY | | | | | | | |
|  | Age | | Significant Health Problems , Including addictive/compulsive behaviors and mental health |  | Age | | Significant Health Problems , Including addictive/compulsive behaviors and mental health |
| Father |  | |  | Children | 🞎 M 🞎 F |  |  |
| Mother |  | |  | 🞎 M 🞎 F |  |  |
| Sibling | 🞎 M 🞎 F |  |  | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | Grandmother Maternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandfather Maternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandmother Paternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandfather Paternal |  | |  |

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| MENTAL HEALTH | | | | |
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| Is stress a major problem for you? | 🞎 | Yes | 🞎 | No |
| Do you feel depressed? | 🞎 | Yes | 🞎 | No |
| Do you panic when stressed? | 🞎 | Yes | 🞎 | No |
| Do you have problems with eating or your appetite? | 🞎 | Yes | 🞎 | No |
| Do you cry frequently? | 🞎 | Yes | 🞎 | No |
| Have you ever attempted suicide? | 🞎 | Yes | 🞎 | No |
| Are you suicidal now? | 🞎 | Yes | 🞎 | No |
| Have you ever seriously thought about hurting yourself? | 🞎 | Yes | 🞎 | No |
| If yes, please describe how you would/do hurt yourself: | | | | |
| Do you have trouble sleeping? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor? If yes, whom? | 🞎 | Yes | 🞎 | No |
| Have you ever been hospitalized for any psychological matters? | 🞎 | Yes | 🞎 | No |

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| --- | --- | --- | --- | --- | --- |
| **Primary Reason(s) for Seeking Services:** | | | | | |
| *Please check any of the following that apply to you. Place an ‘****F****’ by any that apply to a family member.* | | | | | |
| 🞎 | Anger Management/ Aggression | 🞎 | School/ Learning/ Developmental Issues | 🞎 | Work/ Employment Issues |
| 🞎 | Anxiety | 🞎 | Grief/ Loss | 🞎 | Weight/ Eating Disorders |
| 🞎 | Depression | 🞎 | Marriage/ Relationships Issues | 🞎 | Suicidal Thoughts/ Hurting Self |
| 🞎 | Crying spells | 🞎 | Affair | 🞎 | Homicidal Thoughts/ Harming Others |
| 🞎 | Sleeping Problems | 🞎 | Separation/ Divorce | 🞎 | Financial problems |
| 🞎 | Trauma/ Experienced life threatening event | 🞎 | Family/ Relationship Issues | 🞎 Sexual Concerns | |
| 🞎 | Alcohol usage | 🞎 | Parenting / Behavior Problems | 🞎 Problems with Pornography | |
| 🞎 | Drug usage | 🞎 | Mental confusion /Psychosis | 🞎 Frequent lying/ Deceitfulness | |
| 🞎 | Loss of interest in activities | 🞎 | Poor Concentration | 🞎 | Panic Attacks |
| 🞎 | Decreased motivation | 🞎 | Racing or scrambled thoughts | 🞎 | Gambling problems |
| 🞎 | Difficulty enjoying things | 🞎 | Memory problems/ Memory loss | 🞎 | Excessive fear |
| 🞎 | High/ Low energy | 🞎 | Feelings of inadequacy | 🞎 | Destructive behaviors |
| 🞎 | Guilt/ Shame | 🞎 | Withdrawing from others/ Isolation | 🞎 | Insecurity |
| 🞎 | Hopelessness | 🞎 | Loneliness | 🞎 | Impulsive Behaviors |
| 🞎 | Flashbacks | 🞎 | Muscle tensions/ Aches | 🞎 | Thoughts of running away |
| 🞎 | People are out to get me/ Hurt me | 🞎 | Feelings of frustration | 🞎 Mood Swings | |
| 🞎 | Medical concerns | 🞎 | Hear/see things others do not | 🞎 Other: | |
| 🞎 Other: | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SPIRITUALITY** | | | | | | | | |
| *Please indicate below how much Spiritual and Biblical guidance and counseling you would like involved in your counseling sessions.* | | | | | | | | |
| 🞎 None | 🞎 Very little | | 🞎 Some | 🞎 Balanced amount | | | 🞎 Heavy Biblical | |
| *Would you like for your counselor to pray with you in sessions?* | | | | | 🞎 Yes | | | 🞎 No |
| If yes, please indicate the frequency: | | 🞎 Beginning of session | | 🞎 End of session | | 🞎 Beginning & End | | |

Please summarize your goals or desired outcomes for counseling/therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_