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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 |
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| 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 |  |  | GrandmotherMaternal |  |  |
| 🞎 M🞎 F |  |  | GrandfatherMaternal |  |  |
| 🞎 M🞎 F |  |  | GrandmotherPaternal |  |  |
| 🞎 M🞎 F |  |  | GrandfatherPaternal |  |  |

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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