

**Date:**

**Name:** \_\_\_\_\_

**Sex:** M F Other \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:**

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

**Phone:**

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to call ?

Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to call?

**E-mail:** \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Guarantor Information**

Person Responsible for Payment:

\_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Carrier/ID Number:

\_\_\_\_\_

**Reason for Seeking Counseling**

Who's idea was it for you to seek counseling?

What are your two primary goals for these therapy sessions?

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

What are you currently most concerned about?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Symptoms**

*Please check all the symptoms you are currently experiencing:*

*Depression*

Change of Affect

Depressed mood

Generalized fears

Restless sleep

Diminished energy

Shortness of breath

Excessive sleep

Diminished interest

Feeling disconnected

Other: \_\_\_\_\_

*Anxiety*

Increased irritability

Chest pains

Feelings of guilt

Fears of dying

Other: \_\_\_\_\_

*Sleep Disturbances*

Nightmares

Decreased ability to sleep

Poor concentration

Other: \_\_\_\_\_

*Eating*

Increased appetite

Decreased appetite

Weight gain

Weight loss

Other: \_\_\_\_\_

*Avoidance*

Fear of specific places

Fear of social situations

Other: \_\_\_\_\_

*Post-Traumatic Stress*

Intrusive memories

Hypervigilance

Distress from triggers

Feeling numb

Panic

Other: \_\_\_\_\_

**Alcohol and Drug Use**

Do you drink alcohol? How much do you consume?

\_\_\_\_\_

Do you have a history of drug use?

Yes  No

*If yes, please explain:*

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

**Birth History**

Were you full term?

Please list any birth complications:

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

Were you ever in foster care or adopted?

If so, at what age? \_\_\_\_\_

Were there any prolonged separations from your parents? \_\_\_\_\_

*If so, please describe:*

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

**Medical Information**

Primary Care Physician:

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Current Medications:

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

Any Hospitalizations?

Date and reasons:

\_\_\_\_\_

Other health concerns?

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

Have you ever worried about STDs or pregnancy?

Have you ever been tested? Result?

\_\_\_\_\_

**Education**

What's your current attitude towards school?

\_\_\_\_\_

What's your strongest subject?

\_\_\_\_\_

Have you ever been diagnosed with a learning disability? *If yes, what was the disability?*

\_\_\_\_\_

**Legal**

Have you ever been arrested?

*If yes, write a brief explanation. (Include DUI's):*

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

Do you have any legal issues pending?

*If yes, please explain:*

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

**Social Support System**

Who do you consider to be part of your emotional support system? (Friends, family, etc.)

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

What changes would like to make in your interpersonal relationships?

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

Do computers play a role in your social support system? How so?

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

How many hours do you spend online?  
Daily? \_\_\_\_\_ Weekly? \_\_\_\_\_

**Relationships**

Have you ever been in romantic relationships?

How often do you think about romantic relationships?

How would you describe your current sexual orientation?

- Not interested in relationships
- Not sure
- Heterosexual
- Homosexual
- Bi-sexual
- Questioning

Other: \_\_\_\_\_

Are you currently in a relationship? Any concerns?

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

Have you or your partner ever been identified as the victim or perpetrator of violence?

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

**Family**

What are/were your parents' occupations?

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

Did their jobs involve travel?

How many times did you move and where to?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parents:

- Never Married
- Married – How long? \_\_\_\_\_
- Divorced – How long? \_\_\_\_\_

How would you describe their relationship?

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

Do you have step-parents or any other caretakers in your life? (grandparents, relatives, family friends)

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

List any siblings, gender, age, location:

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

Did your parent(s), family member, or other caregiver ever use physical force with you or any other family members?

*If yes, please explain:*

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

Please describe any significant family issues that you may have concerns about:

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

**Recreation**

What do you like do for fun/recreation?

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Alone:

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With Others:

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How often do you engage in these activities?

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**Strengths**

List 3 of your strengths for each of the areas:

*Mental:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Physical:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Spiritual:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Emotional:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Skills/Talent:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Social:*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Other:*

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**SIGNATURE** (self, parent or guardian)

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**DATE**

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