Date:
Client 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: ▫Home▫Work
(_____)_____- _______
Insurance Carrier/ID Number:______________

Reason for Seeking 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

How often do you drink alcohol and how much do you consume?

☐Daily__________________

☐Weekly__________________

Do you have a history drug use?

☐Yes No

If yes, please explain:

____

____

____

____

Birth History

Were you full term?

Please list any complications:

____

____

____

____

Were you ever in foster care or adopted?

If so what age? _______

Were there any hospitalizations and/or prolonged separations from your parents before age two? _____

If so, please describe:

____

____

____

____

Medical Information

Primary Care Physician:

____

Phone Number: ___________________________

Current Medications:

____

____

Medical History

Any Hospitalizations? Date: _____________

Reasons:

____

Have you ever been tested for STDs?

Result?

____

Have you ever had a head injury?

If yes, were you unconscious as a result?

For how long? _______________

Are you currently experiencing any of the following?

☐Frequent headaches

☐Memory loss

☐Difficulty concentrating

☐Difficulty verbalizing what you want to say

Any other health concerns?

____

____

How often do you exercise? ___________________

What types of exercise?

____

Describe your eating patterns for a typical day?

____

____

____

How much water do you drink daily? ___________

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:

____

____

____

____

____

____

____

____

Self-Assessment

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:

____
____
____

Social Support System

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

____
____
____

What changes would like to make in your interpersonal relationships?

____
____
____

Do computers play a role in your social support system?
If yes, please explain.

____
____
____

How many hours do you spend online?
Daily? ______________ Weekly? ______________

Relationships

Please list significant relationships since age 18:

____
____
____
____
____

Current Relationship Status:

☐ Divorced/Separated
☐ Married
☐ Committed relationship
☐ Occasional dating
☐ New relationship
Other: ______________________________________

If currently in relationship:
Length of relationship: ______________________
Ages when you met: Me_______ Partner_________

If separated, how many times? _____________
How long? ______

Has your current partner ever been identified as the victim or perpetrator in a domestic violence incident by the police, court system or other legal agency?
If yes, please explain:

____

____
____

Parenting

Name(s) and Age(s) of child(ren):
____
____
____

Live with:
____

Location:
____

Parenting Plan?
____
____

What are two positive aspects of your relationship with the above identified children?
1.____
____
2.____
____

What are two areas you believe need improvement in your relationship with the above identified children?
1____
____
2.____
____

What is your role in disciplining the children?
____
____
____
____

What types of discipline do you use?
____
____
____
____
____

Family of Origin

Parents:

- ☐ Never Married
- ☐ Married – How long? _____________
- ☐ Divorced – How long? _____________

How would you describe their relationship with each other?
____
____
____

List any siblings, gender, age, location:
____
____
____
____
____

Did your parent(s), family member, or other caregiver use physical force with any of your siblings or other family members?
If yes, please explain:
____
____
____
____

Please describe any significant family of origin issues that may contribute to your current distress:
____
____
____
____

Occupational History

Current Occupation: ______________________

Current Location: ________________________

What do you like and dislike most about your current occupation?

____
____
____
____

Does it involve travel? How much?

____

Please list past occupations of significance and location:

____
____
____
____
____
____
____

Other countries you have lived in and for what purpose:

____
____
____
____
____

____
____
____

Educational Background

Please list your educational and/or training accomplishments and location:

____
____
____

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

____

Recreation

What do you like do for fun/recreation?

____
____
____

Alone:

____

With Others:

____

How often do you engage in these activities?

____

SIGNATURE

____

DATE:

____