Client Information

Name:_____ **Date:**_____

Street address: _____ **Birthdate:** _____

City_____ **SSN:** _____

State & Zip code _____

Home Phone: _____ Is it OK to leave a message? _____yes _____no

Cell Phone: _____ Is it OK to leave a message? _____yes _____no

Texting OK? _____yes _____no

E-mail: _____ Is it OK to leave a message? _____yes _____no

Will you be using insurance or paying out of pocket? _____

If using insurance, who is your carrier?

_____

Signature for Authorization to Bill Insurance _____

Employer: _____ Occupation: _____

Referral Source: _____

Spouse / Partner Contact Info:

Name:_____ Birthdate_____

Address:_____ Phone: _____

_____

Relationship status (married, living together, separated, divorced, engaged,dating?)

_____ Number of years together? _____

Rate the quality of your relationship: __poor __somewhat good __average __above avg___great

In case of an emergency who should I contact?

Name:_____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Personal Strengths:
How would you describe yourself? _____
What activities do you enjoy?_____
Who are the friends you feel close to?_____
Which family member(s) do you feel closest to?_____

Reasons for Seeking Counseling:
What brings you here today?_____
_____
Whose idea was it for seeking counseling?_____
Do you feel counseling is a good idea? Why or why not?_____
_____

Medical History:
Have you ever spoken with a counselor before: If so, briefly describe your experience:_____
_____
What I found most helpful:_____
_____
What I found least helpful:_____
_____

Describe your current physical health: good, fair, poor? _____ Please explain any recent hospitalizations
_____
Please list any medications you are currently taking:
Medication name - dosage - how often (daily? As needed?) - ever miss a dose? How often?
1._____
2._____
3._____
4._____
Describe side effects you have experienced from medications:_____

Alcohol & Drug Use History:

1.Do you currently use tobacco?___yes ____no (if No, then skip to question 2)
How often? ___daily ___weekly ___occasionally ___rarely
How much? ___ # of uses per time.
Do you have a desire to quit? ___no ___somewhat ___strong
2.Do you currently use alcohol? ___yes ___no (if No, then skip to question 3)
How often? ___daily ___weekly ___occasionally ___rarely
How much? ___ # of drinks per time.
Do you have a desire to quit? ___no ___somewhat ___strong
3.Do you currently use any drugs? ___yes ___no (if No, then skip to question 4)
Type of drug(s) used? _____How often? ___daily ___weekly ___oc ___rarely
How much? ___ # of pills and/or _____dosage per time.
Do you have a desire to quit? ___no ___somewhat ___strong
4. Do you use more than one substance at a time to get high ___yes ___no
5.Do you avoid family activities so you can use? ___yes ___no
6. Do you have a group of friends who also use? ___yes ___no
7. Do you use to improve your emotions such as when you feel sad or depressed? ___yes ___no

Background Family History:

1. Are your biological parents ___married ___separated ___divorced
2. Do you think their relationship is good? ___yes ___no ___unsure
3. Who was present during your childhood? (entire childhood? part of childhood?)
   Mother _____ Step Mother_____
   Father_____ Step Father _____
   Brother(s)_____
   Sister(s)_____
   Other(s) _____
   I was number ____ in a family of ____ children
4. How did you get along with your mother as a child? __poorly __average __well
   How do you get along with her now? __poorly __average __well
5. How did you get along with your father as a child? __poorly __average __well
   How do you get along with him now? __poorly __average __well
6. Have you experienced any abuse as a child in your home? ___yes ___no
   If yes, please describe the type of abuse (physical, verbal, emotional, sexual)
   _____
   Have you ever talked with anyone about the abuse? ___yes ___no
7. Have you experienced any abuse as a child outside of your home? ___yes ___no
   If yes, please describe the type of abuse (physical, verbal, emotional, sexual)
   _____
   Have you ever talked with anyone about the abuse? ___yes ___no

Current Family or Relationship Concerns (check all that apply):

___physical fighting
___verbal fighting
___feeling unconnected
___loss of fun
___lack of honesty
___education problems
___financial problems
___illness of a family member
___death of a family member
___abuse / neglect
___feeling unsafe at home
___loss or change of job
___disagreeing about relatives
___disagreeing about friends
___alcohol use
___drug use
___relational problems (adults)
___infidelity (adults)
___divorce / separation
___birth of a sibling
___step parent issues
___step sibling issues

Other concerns not listed above: _____

Current Household and Family Information:

Name	Age	M/F	Relationship (parent, child, step, etc)	Living with you?	% time with them?
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____

Please check the <u>current</u> symptoms or concerns below as they apply to you over the <u>past month</u>:

Rate intensity of symptoms *currently* present as:

0; None = This symptom not present at this time
1; Mild = This symptom impacts *quality* of life, but no significant impairment of day-to-day functioning
2; Moderate = This symptom has a *significant impact on quality* of life and/or *day-to-day functioning*
3; Severe = This symptom has a *profound impact on quality of life and/or day-to-day functioning*

- o depressed mood _____
- o appetite changes_____
- o laxative/diuretic abuse _____
- o sleep disturbance _____
- o eating disorder _____
- o purging_____
- o paranoid thoughts _____
- o fatigue/low energy _____
- o physical coordination _____
- o low self-esteem _____
- o poor concentration_____
- o delusions _____
- o poor grooming _____
- o hallucinations _____
- o mood swings _____
- o aggressive behavior _____
- o agitation _____
- o behavior problems _____
- o emotionality _____
- o alcohol/drug problems_____
- o irritability/annoyance _____
- o anxiety _____
- o grief _____
- o panic attacks _____
- o hopelessness _____
- o fears/phobias _____
- o loneliness _____
- o guilt _____
- o disorganization _____
- o suicidal attempts _____
- o indecisiveness_____
- o nausea/ upset stomach _____
- o elevated mood _____
- o hyperactivity _____
- o detachment from others_____
- o physical pain _____
- o self-harming behaviors _____
- o significant weight gain/loss _____
- o suicidal thoughts _____
- o emotional trauma victim _____
- o problems with a child _____
- o physical trauma victim _____
- o problems with an adolescent _____
- o sexual trauma victim _____
- o work/employment problems _____
- o body image issues _____
- o flashbacks _____
- o impulsivity_____
- o feelings of hopelessness _____
- o recurring thoughts _____
- o oppositional behavior _____
- o hoarding behaviors _____
- o medical condition_____
- o sexuality concerns_____
- o problems with aging parents_____
- o relationship problems _____
- o feelings of worthlessness _____
- o obsessions/compulsions _____
- o binging/purging_____
- o spiritual concerns_____

Thank you!