LOGO

HEADER
PHONE
WEBSITE

GENERAL INFORMATION

Date: _____ How did you hear about us? _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Rev. _____

Nick Name: _____ Name you prefer: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Parent / Guardian: _____ Relationship: _____

CONTACT INFORMATION

Street Address: _____ Suite / Apartment Number: _____

City: _____ State: _____ Zip: _____ May we send mail here? ☐ Yes ☐ No

Mailing Address of Post Office Box: _____

City: _____ State: _____ Zip: _____ May we send mail here? ☐ Yes ☐ No

Home Phone: (_____) _____ May we leave a message here? ☐ Yes ☐ No

Mobile Phone: (_____) _____ May we leave a message here? ☐ Yes ☐ No

Work Phone: (_____) _____ May we leave a message here? ☐ Yes ☐ No

Email Address: _____ May we send Email here? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average hours worked per week: _____

Average Annual Salary:

☐ $0 to $10,000 ☐ $20,001 to $40,000 ☐ $50,001 to $60,000 ☐ $80,001 to $100,000

☐ $10,001 to $20,000 ☐ $40,001 to $50,000 ☐ $60,001 to $80,000 ☐ More than $100,000

EDUCATIONAL INFORMATION

Last year of school completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 College: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Other: _____

Are you currently in school? ☐ Yes ☐ No If yes, what school? _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you content with your current status? ☐ Yes ☐ No If no, briefly explain: _____

If Married, how long? _____ Number of previous marriages for you: _____ For your partner: _____

If Separated or Divorced, how long? _____ If Widowed, how long? _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Rev. _____

How long have you known your partner? _____ Partner's Age: _____

Partner's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Partner's Preferred Name: _____ Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average hours worked per week: _____

Last year of school partner completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 College: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Other: _____

What words would you use to describe your partner? _____

Is your partner supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ Partner doesn't know

With whom do you currently live? ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s)

(Check all that apply) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List your children (living or deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with you?	Describe Him / Her

Have you ever placed a child for adoption? ☐ Yes ☐ No If Yes, when? _____

Have you ever had a miscarriage or medical abortion? ☐ Yes ☐ No If Yes, when? _____

FAMILY OF ORIGIN

List Mother, Father, Brother(s), Sister(s), Step Family, and any Other family members who affected you positively or Negatively

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling)*	Occupation	Describe Him / Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are you currently receiving medical treatment? ☐ Yes ☐ No If Yes, please specify: _____

List any conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments you have had (if more space is needed, speak to your counselor):

_____

MEDICATIONS

List all current medications you are taking, including those you seldom use or take only as needed (if more space is needed, speak to your counselor):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

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Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are you taking these medication(s) according to your doctor's recommendations? ☐ Yes ☐ No

If No, briefly explain: _____

PHYSIOLOGICAL SYMPTOMS

Headaches	☐ Past	☐ Present	Dizziness	☐ Past	☐ Present	Stomach Trouble	☐ Past	☐ Present
Visual Trouble	☐ Past	☐ Present	Sleep Trouble	☐ Past	☐ Present	Trouble Relaxing	☐ Past	☐ Present
Weakness	☐ Past	☐ Present	Tension	☐ Past	☐ Present	Rapid Heart Rate	☐ Past	☐ Present
Difficulty breathing	☐ Past	☐ Present	Intestinal Trouble	☐ Past	☐ Present	Hearing Noises	☐ Past	☐ Present
Change in appetite	☐ Past	☐ Present	Fatigue	☐ Past	☐ Present	Pain	☐ Past	☐ Present
Hearing voices	☐ Past	☐ Present	Seeing Things	☐ Past	☐ Present	Other	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ Has your weight changes in that last 2-3 Months? _____

CURRENT STATUS

Please check any of the following problems which pertain to you and/or your family:

Stress	☐ Past	☐ Present	Nervousness	☐ Past	☐ Present	Anxiety	☐ Past	☐ Present
Panic	☐ Past	☐ Present	Unhappiness	☐ Past	☐ Present	Depression	☐ Past	☐ Present
Guilt	☐ Past	☐ Present	Apathy	☐ Past	☐ Present	Terminal Illness	☐ Past	☐ Present
Recent Death	☐ Past	☐ Present	Grief	☐ Past	☐ Present	Hopelessness	☐ Past	☐ Present
Inferiority Feelings	☐ Past	☐ Present	Defective Feelings	☐ Past	☐ Present	Loneliness	☐ Past	☐ Present
Shyness	☐ Past	☐ Present	Fears	☐ Past	☐ Present	Friends	☐ Past	☐ Present
Marriage	☐ Past	☐ Present	Communication	☐ Past	☐ Present	Physical Abuse	☐ Past	☐ Present
Emotional Abuse	☐ Past	☐ Present	Verbal Abuse	☐ Past	☐ Present	Sexual Abuse	☐ Past	☐ Present
Temper	☐ Past	☐ Present	Anger	☐ Past	☐ Present	Aggressiveness	☐ Past	☐ Present
Bad Dreams	☐ Past	☐ Present	Concentration	☐ Past	☐ Present	Racing Thoughts	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory	☐ Past	☐ Present	Loss of Control	☐ Past	☐ Present
Impulsive Behavior	☐ Past	☐ Present	Self-Control	☐ Past	☐ Present	Compulsivity	☐ Past	☐ Present
Sexual Problems	☐ Past	☐ Present	Pregnancy	☐ Past	☐ Present	Abortion	☐ Past	☐ Present
Legal Matters	☐ Past	☐ Present	Trauma	☐ Past	☐ Present	Eating Problems	☐ Past	☐ Present
Drug Use	☐ Past	☐ Present	Alcohol Use	☐ Past	☐ Present	Trouble with Job	☐ Past	☐ Present
Career Choices	☐ Past	☐ Present	Ambition	☐ Past	☐ Present	Making Decisions	☐ Past	☐ Present
Children	☐ Past	☐ Present	Being a Parent	☐ Past	☐ Present	Finances	☐ Past	☐ Present
Recent Loss	☐ Past	☐ Present	Disaster	☐ Past	☐ Present	Smoking Cigarettes	☐ Past	☐ Present

LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below (1 = Very Little Distress; 10 = Extreme Distress):

1	2	3	4	5	6	7	8	9	10

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

If Yes, when and how? _____

Have any of your friends or family ever committed or attempted suicide? ☐ Yes ☐ No

If Yes, when and who? _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (*i.e. What are your Issues, Problems?*):

Why have you decided to come for counseling now?

What do you hope to gain or change by coming for counseling?

How long do you believe counseling should last? _____

PREVIOUS COUNSELING

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement, if any. Are there any special religious, cultural, or ethnic considerations we should be aware of?

Church attendance? ☐ Yes ☐ No If Yes, what is the name? _____

Do you have a personal support system? ☐ Yes ☐ No If Yes, who? _____

TERMS OF SERVICE

I hereby give COMPANY NAME permission to provide counseling services for the client mentioned above:

Signed: _____ Date: _____

Printed Name: _____

LOGO

Authorization of Release

I, _____, hereby authorize COMPANY NAME, ADDRESS

CITY, STATE ZIP, to:

☐ Release To ☐ Release From ☐ Exchange written and/or oral communication

☐ Psychiatric ☐ Psychological ☐ Medical ☐ Counseling

from the records of: _____ _____

Name of Client Date of Birth

To: _____

_____

For the purpose of: ☐ Outpatient Counseling ☐ Coordination with schools ☐ Send thank you card for referral

☐ Coordination with MD / Psychologist / OT Therapist / Therapist

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on: _____

_____ Date: _____

Client, Parent, Guardian Signature

_____

Client, Parent, Guardian Printed Name

_____ Date: _____

Witness Signature

_____

Witness Printed Name