



NAME
PHONE
FAX

GENERAL INFORMATION

Date: _____ How did you hear about us? _____

Full Name: Mr. Mrs. Ms. Miss Dr. _____

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 Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ 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

would like to be added to Life Counseling Solutions Newsletter to receive free articles, tips and resources: 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

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What School: _____

ADDRESS

WEBSITE



NAME
PHONE
FAX

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. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____ Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED 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 (Check All that Apply): Alone Spouse Children Parent(s) Sibling(s)
 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, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

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

ADDRESS

WEBSITE



NAME
PHONE
FAX

--	--	--	--	--	--

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ 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 (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

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

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Dizziness.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Stomach Trouble..	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Visual Trouble...	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Sleep Trouble....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Trouble Relaxing..	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Weakness....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Tension.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Rapid Heart Rate.	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Difficulty Breathing..	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Intestinal Trouble..	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Hearing Noises..	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Change in Appetite.	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Tiredness.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Pain.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Hearing Voices..	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Seeing Things....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Other.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Nervousness... .	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Anxiety.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Panic.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Unhappiness... .	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Depression.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Guilt.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Apathy.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Terminal Illness....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Recent Death....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Grief.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Hopelessness....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Inferiority Feelings..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Defective Feelings..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Loneliness....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Shyness.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Fears.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Friends.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Marriage.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Communication..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Physical Abuse..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Emotional Abuse..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Verbal Abuse....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Sexual Abuse....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Temper.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Anger.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Aggressiveness....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Bad Dreams....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Concentration....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Racing Thoughts..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Unwanted Thoughts	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Memory.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Loss of Control..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Impulsive Behavior.	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Self-Control.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Compulsivity....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Sexual Problems..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Pregnancy....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Abortion.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Legal Matters.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Trauma.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Eating Problems..	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present
Drug Use.....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Alcohol Use....	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present	Trouble with Job...	<input type="checkbox"/> o Past	<input type="checkbox"/> o Present

ADDRESS

WEBSITE

NAME
PHONE
FAX

LOGO

Career Choices...o Past o Present
Children..... o Past oPresent
Recent Loss....o Past o Present

Ambition..... o Past o Present
Being a Parent...o Past oPresent
Disaster.....o Past o Present

Making Decisions.oPast o Present
Finances..... o Past oPresent
Smoke Cigarettes.o Past o Present

ADDRESS

WEBSITE



NAME
PHONE
FAX

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. Have You Experienced Them in the Past: Yes No

Have You Ever Attempted Suicide: 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

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (*Use Back If Necessary*):

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? If so, 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: _____

ADDRESS

WEBSITE

LOGO

NAME
PHONE
FAX

Authorization of Release

I, _____, hereby authorize COMPANY NAME, ADDRESS, CITY, STATE ZIP to:

____ Release To _____ Release from _____ Exchange Written and/or Oral Communication

____ Psychiatric ____ Medical

____ Psychological ____ 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 _____

Client, Parent, Guardian Date _____

Witness Date _____

ADDRESS

WEBSITE