**Personal:** **Date:**   /  /

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name |       | First Name |       | Initial |    |
| Social Security Number |    -  -     | Referred by |       |
| Address |       |
| City |       | State |    | Zip |      -     |
| Home Phone | (   )   -     | Work Phone | (   )   -     | Cell Phone | (   )   -     |
| May I contact you at home? |       | Work: |       | Cell: |       |
| Birth Date |   /  /     | Age |       | Male |   | Female |   |
| Occupation |       | Highest Level of Education |       |
| Marital Status: |
| Single |   | Married |   | Widowed |   | Divorced |   | Separated |   | If married, how long? |   |
| Is your spouse supportive of you seeking counseling? |       |
| Do you have children? |       | Names and Ages |       |
| In case of emergency, please notify: |       | Phone | (   )   -     |

**Medical History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently under medical care: |       | If yes, please indicate reason |       |
| Physician’s Name |       | Phone | (   )   -     |
| Do you take prescription medications? |     | If yes, what are they? |       |
| Prescribing Physician’s Name, if different from above |       | Phone | (   )   -     |
| List any psychiatric/mental health medications you have taken |       |
| Date and outcome of last physical exam |       |
| Other significant medical history |       |

**Counseling History:**

|  |  |
| --- | --- |
| Have you previously seen a counselor/therapist/psychologist/psychiatrist? |       |
| Name/Date/Location |       |
| When was your last appointment with any of the above? |       |
| Reason for terminating last counseling |       |
| Have you ever been admitted to a mental health care facility? |       |
| If so, date and location? |       |
| Have you ever attempted suicide? |     | Have any family members attempted suicide? |     |
| State in your own words the reason you are seeking counseling: |
|       |
| How do you hope counseling will help? |
|       |
| Is there anything else that you feel is important for your counselor to know? |
|       |

**Please place an “X” by any of the following struggles that pertain to you.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   Nervousness |   Health Problems |   Unhappiness |   Alcohol Use |   Honesty |
|   Sexual Problems |   Suicidal Thoughts |   Compulsive Habits |   Divorce |   Ambition |
|   Financial Struggles |   Work Problems |   Concentration |   Relaxation |   Loneliness |
|   Anger |   Self-control |   Temper |   Memory |   Stress |
|   Career Choices |   Drug Use |   Children |   Decision Making |   Parents |
|   Eating Disorders |   Tiredness |   Depression |   Impulsiveness |   Education |
|   Grief/Loss |   Appetite |   Doubts about God |   Marriage |   Intimacy |
|   Relationships |   Inferiority Feelings |   Separation |   Shyness |   Friends |
|   Thought Patterns |   Sleep Problems |   Nightmares |   Addictions |   Fears |

|  |
| --- |
| Briefly describe your childhood family: |
|       |