**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: |
|  |