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Mailing Address:
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Today's Date: _____

A. Identification

1. Name: _____

Gender: _____

Date of birth: _____ Age: _____ Social Security number: _____

Home address: _____

City: _____State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Please list any communication or texting restrictions: _____

_____

2. Marital status: __Single __Partnered __ Married __Divorced __Widowed

3. Spouse/Partner's name: _____ Date of birth: _____ Age: _____

Address: _____

City: _____State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Spouse/partner currently employed: __ Yes __ No

Spouse/partner current employer: _____ Work phone: _____

B. Employment

Currently employed: __ Yes __ No

Current employer: _____ Work phone: _____

Address: _____

_____

Please list any communication or texting restrictions: _____

_____

C. Insurance

Primary Insurance

Responsible Party: _____

Employer: _____

Date Employed: _____

Social Security #: _____

Date of Birth:_____

ID Number: _____

Group ID Number: _____

Secondary Insurance

Responsible Party: _____

Employer: _____

Date Employed: _____

Social Security #:_____

Date of Birth: _____

ID Number: _____

Group ID Number: _____

D. Referral: Who gave you my name to call?

Name: _____ Phone: _____

E. Emergency Information

Emergency contact person: _____

Relationship: _____ Phone number: _____

F. Chief Concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

G. Abuse History

Please list any emotional, physical or sexual abuse below. Use an E for Emotional, a P for physical and an S for sexual abuse.

Person who abused you	Age(s) of abuse	Relationship to abuser	Type (E, P, or S)

H. Checklist of concerns

Check all that apply to you:

__ Abuse (Current emotional, physical, sexual, verbal)
__ Abuse (Past emotional, physical, sexual, verbal)
__ Aggression/violence
__ Alcohol/substance use
__ Alcohol/substance use of loved one
__ Anxiety, nervousness
__ Attention, concentration, distractibility
__Childhood issues (your own)
__ Depression, low mood, sadness
__ Divorce, separation, remarriage
__ Eating problems
__ Fatigue, tiredness, low energy
__ Financial, money issues, debt, spending
__ Gambling
__ Grieving, mourning, losses, deaths
__ Health issues, medical concerns
__ Homicidal thoughts
__ Impulsiveness, loss of control, outbursts
__ Internet issues
__ Legal matters, charges, suits
__ Memory problems, concentration
__ Mood swings
__Obsessions, compulsions (repeated thoughts)
__ Panic attacks
__ Parenting, child management, single parent
__ Partner/marital conflict, distance, infidelity
__ Pornography use
__ Relationship problems (friends, relatives, co- workers)
__ Self-esteem
__ Self-harm/self-injurious behaviors
__ Sexual issues (dysfunctions, conflicts, sexual orientation, gender identity, sexual addictions)
__ Sleep problems – too much, too little
__ Stress, relaxation, stress management
__ Suicidal thoughts or attempts
__ Temper problems, self-control
__ Trauma survivor or witness
__ Weight and diet issues
__ Work problems, employment, job dissatisfaction, unable to keep a job
__ Other (specify): _____

I. Living Environment

List all people living in the home. Indicate which children are from a previous marriage or relationship with the letter P in the last column.

Name	Relationship	Date of birth	P

Children not living in the home:

Name	Relationship	Date of birth	P

J. Health (Physical) History

1. Primary care doctor/clinic's name: _____

Phone: _____

Address: _____

_____

May I contact your medical doctor so that he or she can be fully informed, and we can coordinate treatment? ___ Yes ___No

2. List all medications, drugs, or other substances you take or have taken in the last year prescribed, over-the-counter vitamins, herbs, and others:

Medication/drug	Dose	Taken for	Prescribed and supervised by

3. List significant illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions:

Condition	Age	Treated by whom?	Consequences

4. Health Habits:

a. What kinds of physical exercise do you participate in? How often? _____

_____

b. How much coffee, tea, cola or other sources of caffeine do you consume each day? ___

_____

5. Chemical Use

a. Have you ever felt the need to cut down on your drinking? __No __Yes

b. Have you ever felt annoyed by criticism of your drinking: __ No __ Yes

c. Have you ever felt guilty about your drinking? __ No __Yes

d. How much beer, wine, or hard liquor do you consume each week, on the average?_____

e. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____

f. How much tobacco do you smoke or chew each week? _____

g. Do you vape? __ No __Yes If yes, what substance do you vape? _____

How many pods per day? _____ Per week? _____

h. Which drugs (not medications), substances or other chemicals have you used in the last 10 years?

_____

_____

i. Which do you currently use and how often? _____

K. Mental Health/Counseling History

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ___ No ___Yes If yes, please indicate:

Date	Provider	Presenting Problem	Results

2. Have you ever taken medications for psychiatric or emotional problems? __No __ Yes
If yes, please indicate:

Date	Provider	Medications	Presenting Problem	Results

L. Personal strengths and problem areas

Personal strengths: _____

_____

_____

Personal problem areas: _____

_____

_____

M. Legal

1. Do you have any current legal matters? __No __Yes

If yes, please explain: _____

_____

2. Have you ever been

a. Charged with a crime: __No __Yes

If yes, please explain:

_____

b. Convicted of a crime: __No __Yes

If yes, please explain:

_____

c. Arrested __No __Yes

If yes, please explain:

_____

d. Incarcerated __No __Yes

If yes, please explain:

_____

N. Other

Is there anything else I should know that does not appear on this form that may be helpful to our counseling sessions?

_____

_____

_____

_____

_____

_____

_____

_____

_____