



Name		Nickname	
Gender	Date of Birth	Marital Status	Employment Status
Home Address			
City, State, Zip			
Home Phone		Work Phone	
Cell Phone		Cell Phone Carrier	
Email Address			
Emergency Contact (Name, relationship, phone)			

How would you like appointment reminders to be sent to you?

- Email
  Text Message
  Phone Call
  None

**If insurance will be used, please fill in the following**

Insurance Company	
Insured Person's Name (usually the employee)	
Insured's Street Address	
Insured's City, State, Zip	
Insured's Phone Number	
Insured's Date of Birth	Insured's Gender
Employer (of the insured)	
I.D. Number (found on the insurance card)	
Group Number (if on insurance card)	
Insurance Phone Number (usually on card's back)	

Why are you seeking counseling? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Check the box beside each concern experienced recently.**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Depression          | <input type="checkbox"/> Sleep problems        | <input type="checkbox"/> Thoughts of suicide        |
| <input type="checkbox"/> Panic              | <input type="checkbox"/> Unusual thoughts    | <input type="checkbox"/> Anger outbursts       | <input type="checkbox"/> Changes in weight          |
| <input type="checkbox"/> Crying spells      | <input type="checkbox"/> Memory problems     | <input type="checkbox"/> Sexual problems       | <input type="checkbox"/> Relationship difficulties  |
| <input type="checkbox"/> Treated unfairly   | <input type="checkbox"/> Frequent pain       | <input type="checkbox"/> Low energy            | <input type="checkbox"/> Concentration problems     |
| <input type="checkbox"/> Restlessness       | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Eating disorder       | <input type="checkbox"/> Legal difficulties         |
| <input type="checkbox"/> Drug use           | <input type="checkbox"/> Drinking problem    | <input type="checkbox"/> Boredom               | <input type="checkbox"/> Hopelessness               |
| <input type="checkbox"/> Stress             | <input type="checkbox"/> Shyness             | <input type="checkbox"/> Work problems         | <input type="checkbox"/> Confusion                  |
| <input type="checkbox"/> Guilt feelings     | <input type="checkbox"/> Suspicion           | <input type="checkbox"/> Loneliness            | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Compulsions        | <input type="checkbox"/> Worry               | <input type="checkbox"/> Money problems        | <input type="checkbox"/> Difficulty with decisions  |
| <input type="checkbox"/> Specific fears     | <input type="checkbox"/> Mourning            | <input type="checkbox"/> Physical illness      | <input type="checkbox"/> Poor motivation            |
| <input type="checkbox"/> Feeling abandoned  | <input type="checkbox"/> Meaninglessness     | <input type="checkbox"/> Perfectionism         | <input type="checkbox"/> Unusually sensitive        |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Social withdrawal   | <input type="checkbox"/> Feeling misunderstood | <input type="checkbox"/> Troublesome thoughts       |
| <input type="checkbox"/> Religious concerns | <input type="checkbox"/> Disappointment      | <input type="checkbox"/> Impulsive             | <input type="checkbox"/> Hearing strange voices     |
| <input type="checkbox"/> Feeling inferior   | <input type="checkbox"/> Irrational thoughts | <input type="checkbox"/> Mood swings           | <input type="checkbox"/> No problems or concerns    |

Other additional concerns or symptoms: \_\_\_\_\_

What stresses or life changes have you experienced lately? \_\_\_\_\_

**Have you seen a therapist in the past?**

Year	Problem	Therapist or clinic	How long

**About your childhood**

Check the box beside issues experienced in childhood

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Happy childhood        | <input type="checkbox"/> Neglected          | <input type="checkbox"/> Moved frequently       |
| <input type="checkbox"/> Physically abused      | <input type="checkbox"/> Few friends        | <input type="checkbox"/> Sexually abused        |
| <input type="checkbox"/> Weight problems        | <input type="checkbox"/> Popular            | <input type="checkbox"/> Parents divorced       |
| <input type="checkbox"/> Family fights          | <input type="checkbox"/> Poor grades        | <input type="checkbox"/> Conflict with teachers |
| <input type="checkbox"/> Drug or alcohol use    | <input type="checkbox"/> Good grades        | <input type="checkbox"/> Sexual problems        |
| <input type="checkbox"/> Depressed              | <input type="checkbox"/> 'Spoiled'          | <input type="checkbox"/> Anxious                |
| <input type="checkbox"/> Not allowed to grow up | <input type="checkbox"/> Attention problems | <input type="checkbox"/> Anger problems         |



Additional childhood experiences or symptoms: \_\_\_\_\_

### Your family growing up

Relationship (also list siblings and other significant relationships)	First Name	Personality / Mental Health Issues
Mother		
Father		

### Who lives with you now?

Relationship	First Name	Personality / Mental Health Issues

Where are you currently living?  House  Apartment  With relatives  
 Dorm/campus apartment  Health care facility  Retirement community  Other



### Relationship history

How many times have you been married?	How old were you at the time of your marriage(s)?
Briefly describe any problems in your current or past marriages or cohabitation relationships	

### Education & Occupation

Are you currently... <input type="checkbox"/> Working <input type="checkbox"/> In school <input type="checkbox"/> (both) <input type="checkbox"/> (neither)
Highest level of education so far?
What is (or was) your major or favorite subject?
How many hours per week are you working?
In what field do you usually work?
What is your current or most recent job title?
Briefly describe what you like and dislike about your employment or school

### Home Life

How do you spend personal time? (list hobbies, sports, clubs, groups, family activities, etc.)
How many contacts do you have each month with friends outside of work or school?
Who can you talk with about personal feelings or private matters?
Are you satisfied with your romantic life?
Briefly describe what you like and dislike about your current romantic and friendship lives:



### Health

Check the box beside each accident or illness you have experienced

- |   |  |
|---|--|
| <input type="checkbox"/> Recent surgery               | <input type="checkbox"/> Head injury           |
| <input type="checkbox"/> Seizures                     | <input type="checkbox"/> Thyroid problems      |
| <input type="checkbox"/> Drug/alcohol abuse treatment | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Chronic pain                 | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hormone problems      |
| <input type="checkbox"/> Infertility                  | <input type="checkbox"/> Miscarriages          |

List any other chronic health problems you may have:
How many hours do you sleep in an average night?
How many drinks (containing alcohol) do you consume in an average week?
Which recreational drugs have you used in the last year?
List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:
Do you exercise? How? How often?
Do you use tobacco? How much?
Who is your primary physician? (Include phone number if known)
When was your last physical?
Are you concerned about your physical health?

### Accomplishments / Additional Information

List your personal strengths and important accomplishments
List any additional information that it might be important for your counselor to know