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Parent/Guardian Information

Today's Date _____ Who referred you to me? _____

Parent/Guardian _____ DOB _____ Age _____

Parent/Guardian _____ DOB _____ Age _____

Address _____ _____ _____ _____
street city state zip

Phone (cell) _____ (work/home) _____ Best time to call _____

Email address _____ Social Security Number _____

May I have permission to contact you and leave a message through

☐ Cell VM ☐ Cell Text ☐ Home/Work VM ☐ Email

Marital Status

☐ Single
☐ Engaged
☐ Married (how long) _____ Number of times married _____
☐ Separated (how long) _____
☐ Divorced (how long) _____

Education _____ Occupation _____

Spouse's Name _____ DOB _____ Age _____

Spouse's Education _____ Spouse's Occupation _____

List those in your family: name, birth date, sex and relationship to you (biological, step-children, foster or adoptive children, etc.). Indicate if they are living in your home.

First and last name	Birth Date	Sex	Relationship	At Home?

Minor Client Information

Adolescent/Child's name _____ Age _____ DOB _____

Address: _____

Grade/Education Level _____ Attending School? ☐ Yes ☐ No School Name: _____

Do you share custody of your child? ☐ Yes ☐ No Do you have primary custody? ☐ Yes ☐ No

(If you share custody and have primary custody of your child, please supply a copy of the legal document stating such.)

Please fill out the following information as it applies to the minor client.

Please state why you are seeking counseling. _____

What is the intensity of this problem and the impact on your quality of life? _____

Have you struggled with this issue before? If so, when? How did you handle it before? _____

Describe the first time you felt this way. What were you doing? _____

What does a typical day look like for you?

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

Have you had prior counseling? ☐ Yes ☐ No

If yes, when? _____ Where? _____ With whom? _____

For what purpose? _____

Please tell me about your previous counseling experience. _____

Are you or another family member currently seeing a psychiatrist or another counselor? ☐ Yes ☐ No

If so, which family member? _____ Name of psychiatrist or counselor _____

For what purpose? _____

CRISIS INFORMATION

Do you have any current suicidal thoughts, feelings, or actions? ☐ Yes ☐ No

If yes, explain. _____

_____

On a scale of 1 to 10, with 1 being minimal and 10 being severe, how intense are these feelings? _____

Have you acted on any part of these thoughts? If so, tell me about that. _____

_____

_____

Have you had any suicidal acts or attempts? ☐ Yes ☐ No If yes, how many attempts? _____

Describe the method used _____

_____

Did anyone know of the attempts? _____

Do you have homicidal or assaultive thoughts or feelings, or anger-control problems? ☐ Yes ☐ No

If yes, explain. _____

_____

Have you had any past problems, hospitalizations, or arrests for suicidal or assaultive behavior? ☐ Yes ☐ No

If yes, explain. _____

_____

Have you had any recent significant losses or harm (family relationships, illness, divorce, job loss, etc)? ☐ Yes ☐ No

If yes, explain. _____

_____

Are there any current threats of financial hardship or legal issues? ☐ Yes ☐ No

If yes, explain. _____

_____

Would you or others describe you as impulsive? ☐ Yes ☐ No

If yes, explain. _____

_____

Would you consider yourself a "burden" to others? ☐ Yes ☐ No

If yes, explain. _____

_____

Do you or someone in your home own a firearm? ☐ Yes ☐ No

FAMILY BACKGROUND

Father's Name _____ Age ____ Occupation _____

State of Health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that describe your father (e.g. loving, mean, controlling, etc.) _____

_____

How do/did you get along? _____

Mother's Name _____ Age ____ Occupation _____

State of Health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that describe your mother (e.g. loving, mean, controlling, etc.) _____

_____

How do/did you get along? _____

Step-Father's Name _____ Age ____ Occupation _____

State of Health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that describe your step-father (e.g. loving, mean, controlling, etc.) _____

_____

How do/did you get along? _____

Step-Mother's Name _____ Age ____ Occupation _____

State of Health _____ Resides in _____

If deceased, how long ago was the loss? _____

List three words that describe your step-mother (e.g. loving, mean, controlling, etc.) _____

_____

How do/did you get along? _____

Brothers and sisters. Please list them in birth order.

First and last name	Age	Resides In	Close	Distant	In Between

List family members who have/had or were suspected to have/had a mental illness.

First and last name	Relationship	Mental Illness	Officially Diagnosed?	Hospitalized?

Your happiest memories of you and your family as a child are _____

_____

_____

Your most unpleasant memories of you and your family as a child are _____

_____

_____

Have you ever experienced any of the following?

___ Harsh physical punishment or abuse
___ Sexual advances made toward you as a child
___ Sexual abuse
___ Incest
___ Rape
___ Verbal or emotional abuse by a spouse or lover

If so, please explain

Please be aware of my limits of confidentiality as it pertains to protecting you. I am ethically and legally required to inform your parent or guardian as well as the authorities if you have been sexually or physically abused by an adult, family member, and/or older peer.

SUBSTANCE USE/ABUSE HISTORY

Are you presently or have you in the past used alcohol on a regular basis? ☐ Yes ☐ No

If yes, please list type of drink (e.g. beer, wine, whiskey, etc.), frequency of use, when you began use, and approximate date of last use.

Are you currently, or have you in the past, used any non-prescription drug(s)? ☐ Yes ☐ No

If yes, please list name of drug(s), frequency of use, when you began, and approximate date of last use.

MEDICAL INFORMATION

Please list any current medical problems or symptoms you are concerned about.

1.
2.
3.

Please give information concerning <u>all</u> prescription or over-the-counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

Name	Dosage/How Often	Reason Taken	Taken how long	Reaction

Resiliency and Strengths: Check any areas that apply and add what is unique about you.

___ Supportive social network (friend(s), family, etc.)
___ Responsible to family and others
___ Engaged in work/career (Job satisfaction)
___ Ability to overcome difficult circumstances/events in the past
___ Hobbies/Interests:
___ Frustration tolerance
___ Ability to manage stress
___ Strong desire to live life
___ Pet(s)
___ Other: _____

Check any of the following that you experienced or identify with

___ Anger
___ Detachment/Numbness
___ Nightmares
___ Anxiety
___ Panic attacks
___ Phobias or severe fears
___ Mood swings
___ Racing thoughts
___ Lack of concentration
___ Memory Loss
___ Fainting spells, feeling light headed or dizzy
___ Loneliness
___ Difficulty managing time
___ Difficulty making decisions
___ Low Energy
___ Lack of appetite
___ Shyness
___ Premenstrual syndrome
___ Empty nest
___ Low self-esteem
___ Bullying
___ Feeling of being outside oneself
___ Disorganized thoughts
___ Pornography
___ Peer pressure

Check any of the following that you experienced and indicate how recently

___ Relationship issues/marital conflict _____
___ Separation/Divorce _____
___ Parental or family conflict _____
___ Depression _____
___ Sleep difficulties _____
___ Menopause _____
___ Violence in the home _____
___ Anxiety _____
___ Blacking out _____
___ Hearing voices _____
___ Sexual addiction _____
___ Weight gain or loss _____
___ Sexual issues _____
___ Infidelity _____
___ Pregnancy _____
___ Abortion _____
___ Manic Depression/Bipolar Disorder _____
___ Alcohol abuse/chemical substance use _____
___ Suicidal ideation _____
___ Homicidal ideation _____
___ Self-harm (e.g. cutting) _____
___ Hallucinations _____

Have you experienced a psychiatric hospitalization? When, how long, reason for admission. _____

_____

_____

Have you experienced other mental or emotional problems? Please specify. _____

_____

_____

Prescribing physician's name: _____ Date last seen: _____

Physician's address _____ Phone number _____

Coordinating medical treatment is important for your overall benefit. Please indicate if I may contact your prescribing physician to coordinate your treatment. ☐ Yes ☐ No

Consenting signature (must be parent/guardian)

Signature: _____ Date: _____

Spirituality

Do you consider spirituality meaningful to you? _____

Level of meaningfulness of spirituality now ___high ___medium ___low

Do you have a specific religious affiliation? _____

Additional information regarding your spiritual beliefs _____

_____

Emergency Contact

Name _____ Contact telephone number _____

Relationship to you _____

Client Signature: _____ Date: _____

Parent/Guardian Signature _____ Date: _____