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National Certified Counselor, Licensed Professional Counselor – GA, Licensed Clinical Professional Counselor - ME

To facilitate your initial visit, and to help us focus more clearly on the areas of concern, please answer each question as completely as you can. This will become part of your confidential file.

Today's Date__________________

Name ____pronouns:_____________________

Date of Birth ________________ Age ________

Home Address_______________________________________City_______________________Zip_______

Cell Phone _________________________ May I leave a message at this #? Yes No

Home Phone __________________________ May I leave a message at this #? Yes No

Email address (for appointment information):____

Preferred means of communication: CALL TEXT EMAIL
note: email / text is not a secure means to relay confidential information.

RELATIONSHIP STATUS:

Single_____ Partnership (how long) _____year(s) Married (how long) ______ (year/s)

Number of Previous Marriages _____ Divorced (how long) ______(year/s)

Presently living with (check one): Partner_____ Alone _____ Parent(s)_______ Other ________

Spouse/Partner's Name _______________________________________ Age _________

Children_____________________________ Age ______

_____________________________ ______

_____________________________ ______

_____________________________ ______

Emergency Contact: ____

Relationship: _______________________________ Phone: ____________________________

INSURANCE / EAP:

___ No, I do not wish to utilize insurance / EAP; I will pay out-of-pocket

___Yes, I wish to utilize my insurance / EAP *(note: EAP sessions have an expiration date)*

My I**nsurance** is with ____

_________________________ is my **EAP** provider and my authorization number is ___________________

YOUR EMPLOYMENT:

Employer ____Position/Title:____________________________

Your Work Address: City ____ State___________________

How long with this employer __________ Work Phone ______________________________

Are you currently receiving medical treatment _________ **If yes, for what purpose**__________________

____

Primary Care Physician ___________________________________ Phone:___________________________

List any prescription or over-the-counter medication you take:

Medication	Dosage	Frequency	Purpose

Biological Parents: Number of years they were: Married______ Separated______ Divorced______
If your parents separated or divorced, *how old were you at the time*?___________
Natural Father's occupation ____________________ Natural Mother's occupation _____________________

List your brothers and sisters, giving their names and ages, including yourself:

____

____

Have you ever received counseling before?_________ **If yes, when and why** _________________________

____

Issues you have or have had concern:

Place an X in all columns that apply to a concern or distress you have had during any of the indicated periods of your life	**Current** to 1 year ago	2 – 5 years ago	More than 5 years ago	Ages 23 - 18	Prior to Age 18
Problems with parents					
Depression					
Eating issues / weight changes					
Sleep pattern (too much / too little)					
Anxiousness					
Financial problems					
Legal problems					
Marital / Committed Relationship problems					
Abuse issues of any type					
Self-esteem (low or struggled with low self-esteem)					
Sexual concerns					
Gender identity					
Thoughts of hurting yourself					
Social relationships					
Family / Relatives					
Personal use of alcohol or other substance					
Use of alcohol or other substance by family / relative					
Physical / Health problems					
Spiritual / Religious concerns					
Work problems that caused significant concern					

Unstable home life						

Do you drink alcoholic beverages [ ] Yes, about _________ per: night / week [ ] No
Have you ever thought you should cut down on your drinking? [ ] Yes [ ] No

Have you ever felt annoyed by other's criticism of your drinking? [ ] Yes [ ] No

Have you ever felt guilty about your drinking? [ ] Yes [ ] No

Have you ever considered suicide as a solution to your problems?
[ ] Yes.
When and why:____
[ ] No

Have you ever physically hit someone with your hands or another object?
[ ] Yes
When and why:____
[ ] No

Were you raised in a religious structure / church / denomination?____________________

Do you currently have a preferred religious / spiritual affiliation? ____________________

<u>Please complete the following.</u>
The most important thing to me is______________________________________

I worry about ______________________________________

I have sometimes felt guilty about ______________________________________

I have been criticized for ______________________________________

What makes me angry is ______________________________________

My biggest mistakes were______________________________________

What makes me nervous is______________________________________

I often felt that mother ______________________________________

My temper ______________________________________

Sex to me is ______________________________________

I often felt that father ______________________________________

What hurts me most is ______________________________________

To me, God is ______________________________________

What I want most is ______________________________________

List any additional information you wish for me to know below.

____

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