Client's Name: _____DOB_____

Address_____City_____Zip_____

Preferred phone _____

May I send appointment reminders and receipts via email or text? Y____ N____

If yes, please provide your email address_____

- In order to ensure your privacy, please do not use email to share any clinical or sensitive information.

Emergency Contact:

Name_____Phone_____Relationship_____

Briefly describe your reasons for seeking counseling

_____
_____
_____
_____
_____

Are you currently employed? FT___ PT__ No, but looking for work__

Self-employed___ Retired/Homemaker___

Comments about work: _____
_____

Student? FT ___ PT___

Comments about school: _____-
_____

Current relationship status: Married___ Living w/Partner__ Widowed__ Divorced__

Recent break up__ Separated __ Single __

If you have children and or siblings, please provide the following information:

Name:_____ Age_____ Place of residence _____

Name:_____ Age_____ Place of residence _____

Name _____ Age _____ Place of residence _____

Name _____ Age _____Place of residence _____

Name_____ Age _____ Place of residence _____

What are the most troubling stressors in your life right now and when did they begin?

_____

_____

Overall how do you feel you are coping with the circumstances in your life at the present?

(On a scale of 1 to 10 circle the number that best describes your feelings.)

Not well: 1 2 3 4 5 6 7 8 9 10 Doing Fine

Please list any significant losses you have experienced and the approximate dates (deaths, divorce, job, health):

Nature of loss_____ Date of loss_____

Nature of loss_____ Date of loss_____

Nature of loss _____ Date of loss _____

Nature of loss _____ Date of loss _____

Circle the level of support you are receiving from others (N/A=not applicable)

Family Support	Good	Fair	Poor	N/A
Friends/ Neighbors	Good	Fair	Poor	N/A
Employer/ Co-workers	Good	Fair	Poor	N/A
Church/Clergy	Good	Fair	Poor	N/A

Which of the following are you experiencing at this time? (Circle all that apply)

Sleep difficulties	Reduced energy or fatigue	Legal concerns
Living with a serious illness	Reduced concentration	Family Conflicts
Anxiety, worry or panic	Financial concerns	Difficulty expressing feelings
Impending death of a loved one	Withdrawal from others	Social isolation
Increased alcohol or drug use	Relationship concerns	Change in appetite
Sexual problems	Criminal behavior	

Please list any medications you are currently taking and the conditions/reasons for using:

_____

_____

_____

Please list your primary care provider's contact information:

Name _____Phone _____

Please list other health care providers (including medical specialist, counselors, psychologist or psychiatrist) you have seen in the past twelve months.

Name_____ Phone _____ _____

Name _____ Phone _____

Name _____ Phone _____

Please list any previous medical or psychiatric hospitalization (including dates and circumstances)

_____

_____

What do you hope to accomplish through counseling? _____

_____

_____

If there are other family members/friends you are concerned about, please describe.

_____

_____

I confirm that the information given on this form is accurate to the best of my knowledge at this time. I also acknowledge that I understand the ways in which my health information may be used or disclosed and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of client _____Date _____

Signature of counselor _____Date _____