

General Information

Name _____
Address _____
Home Phone _____ Cell Phone _____
Preferred number for contact _____ Ok to leave a message? _____
Date of Birth _____ Your age today _____ Sex _____
Were you referred to me? _____
If yes, who referred you? _____
If no, how did you hear about me? _____
Occupation _____
Education Level _____

Family

Marital Status _____
Spouse/Partner _____ His/her occupation _____
Children (name, age, sex) _____

Is your father living? _____ Where? _____ Date of Death? _____
His occupation _____
What is/was your relationship with your father like? _____

Is your mother living? _____ Where? _____ Date of Death? _____
Her occupation _____
What is/was your relationship with your mother like? _____

Siblings/Other Important People

Recent changes in your life or those close to you (marriages, deaths, job changes, divorces, moves, serious illness)

Medical

Family Physician _____ Address _____
Significant illnesses, injuries, physical conditions, hospitalizations, etc (give dates) _____

Medications/Drugs now used _____

Previous counselors _____

Interests

Problems/Concerns

Please mark any specific problems or concerns and use the spaces provided to specify if necessary.

- Abuse Survivor Issues
- Abandonment and/or Fear of
- Adjusting to Change / Life Transitions
- Anxiety
- Attachment Issues
- Bereavement
- Bipolar
- Blended Family Issues
- Child and/or Adolescent Issues
- Communication Problems
- Compulsions
- Control Issues
- Creative Blocks
- Depression
- Developmental Disorders (Autism, Aspergers, etc.)
- Dissociation
- Divorce / Divorce Adjustment
- Domestic Violence
- Eating & Food Issues
- Emptiness
- Emotional Abuse
- Emotional Overwhelm
- End-of-life Adjustment
- Family Problems
- Family of Origin Issues
- Grief & Loss
- Habits
- Impulsivity
- Inadequacy
- Infidelity / Affair Recovery
- Isolation (Emotional & Social)
- Life Purpose/Meaning/Inner-Guidance
- Mood Disturbance
- Mood Swings
- Obsessions
- Oppositional & Defiant Behavior
- Panic
- Phobias / Fears
- Physical Abuse
- Post Traumatic Stress
- Relationships & Marriage
- Self-Care
- Self-Doubt
- Self-Esteem
- Self-Harm (Cutting, etc.)
- Sensitivity to Criticism
- Sexual Abuse
- Shame
- Social Phobia/Anxiety
- Stress
- Suicidal (Thoughts, Feelings, and Behaviors)
- Trauma
- Trust Issues
- Violence
- Women's Issues

Other problems/concerns: _____

Insurance Company: _____ ID #: _____ Group #: _____
of Sessions: _____ Auth#: _____ Co-Pay \$: _____ Deduct\$: _____ Deduct. Left? Y/N

Emergency Contact Information	
Name: _____	_____
Address: _____	_____
Phone: _____	Relationship to you: _____

Signature _____	Date _____
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