Application For Counseling

Please read and complete the following questions below. Please bring the completed forms to your first session and be prepared to discuss any questions.

Date _____/_____/_____

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell Phone: ( )_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____ Relationship to you? _____

Telephone Number _____

Referred by (if any): _____

May we contact them to thank them? (Please provide contact information if yes)

_____

EMPLOYMENT INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation: □ Full Time □ Part-time □ Unemployed

□ On Disability □ Minor/not employed

Employer Name _____

Employer Address _____

Job Title: _____

If Student: □ Full-time □ Part-time School/College _____

School Address: _____

2. Do you enjoy your work/school? Is there anything stressful about your current work/school?

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Name of Primary Care Physician (PCP): _____

PCP Address & Phone: _____

■ **I do** / □ **I do not** wish for my PCP to be occasionally informed about my treatment

Signature _____ Relationship to patient _____

Date: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric? services, etc.)?

□ No □ Yes Name of Therapist(s): _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

2. How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

_____

1, How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

_____

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

11. Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

12. Do you have any allergies? _____

13. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

14. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

15. Please describe why you are coming to counseling. (i.e. what are your issues, symptoms, how long, etc. Use the back if necessary.):

_____

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Cf cai	List Family Member
Alcohol/Substance Abuse	☐ yes ☐ no	
Anxiety	☐ yes ☐ no	
Depression	☐ yes ☐ no	
Domestic Violence	☐ yes ☐ no	
Eating Disorders	☐ yes ☐ no	
Obesity	☐ yes ☐ no	
Obsessive Compulsive Behavior	☐ yes ☐ no	
Schizophrenia	☐ yes ☐ no	
Suicide Attempts	☐ yes ☐ no	

Are you currently experiencing any suicidal thoughts? □ No ■ Yes

Have you experienced suicidal thoughts in the past? □ No ■ Yes

Have you attempted suicide in the past? □ No ■ Yes

Are you currently experiencing any violent or homicidal thoughts? □ No □ Yes

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

2. Do you currently attend church, synagogue or other religious institutions regularly?
□ Yes □ No

If yes, which one?_____

Check here if you want Christian counseling: □ Yes □ No

2. What do you consider to be some of your strengths?

_____

_____

3. What do you consider to be some of your weakness?

_____

_____

4. What would you like to accomplish out of your time in therapy?

_____

_____

I certify that all the preceding information (personal, relational, counseling history, medical, present issues and goals) is honest and truthful to the best of my knowledge.

_____ _____

Client Signature Date