Welcome!

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Integrative Counseling

If you are a new client, please answer the questions below.
The information you give will be kept strictly confidential.

Today's Date ___________________

Name ___________________________________ Date of Birth ________________________ Age_________ Sex: M F

Address ____
(Street) (City) (State) (Zip)

Phone: Home (_____) ______________________________ Work (_____)__________________________________

Cell (_____) ______________________________ OK to leave message? Y N

Email ____

Occupation ______________________________ Employer ___________________________ Length Employed ________

Marital Status: Single____ Married____ Separated___ Divorced___ Widowed___

How long? __________________ If previously married, what years? ________________________

Name of Spouse______________________________ Spouse Date of Birth ___________________

Spouse's Occupation & Employer ____

Name of Church or Religious Preference (if any) ____

Emergency contact: ___________________________ Relationship ____________________ Home #_________________

Address: ____ Cell/Work # _________________________________

Please list the people who currently live with you:

Name	**Relationship**	**Age**

For those interested in Sliding scale:

Number of dependents ____________

Gross monthly income for household $ __________________

Name of personal physician ______________________ Date of last medical exam_______________

List important illnesses, injuries, or disabilities, past and present ____

____

Are you presently taking medication? Y N If so, list name(s) and dosage(s) ________________________________

____

Who prescribed? ____ Phone # ____________________________________

Have you ever been hospitalized for mental/emotional difficulties? Y N

If yes, give dates and reason ____

____

____

Has anyone in your family ever had an emotional, mental, or substance abuse problem? Y N

If so, please explain: ____

Name of your Insurance Company _______________________________ Member ID ____________________________

For insurance billing, member name and date of birth ____

Briefly describe the problem(s) for which you are seeking treatment:

____

____

____

On the scale below, please circle the most accurate description of the severity of your problem:

mild moderate difficult severe

When did the problem(s) start? ____

Have you ever received counseling before? Y N If yes, whom did you see? __________________________________

Was it helpful? If so, how? If not, what was not helpful? ____

____

____

____

Please circle any of the following that pertain to you:

Anxiety
Adoption
Anger
Alcohol use
Childhood abuse
Concentration
Death of loved one
Depression
Drug use
Eating problems
Fears/Worry
Financial problems
Feel guilty
Headaches
Health problems
Inferior/Worthless feelings
Legal matters
Loneliness
Making decisions

Marriage problems
Miscarriage/Termination of pregnancy
Negative thoughts
Nightmares
Over/Under Ambitious
Poor self-control
Physical/Sexual Assault
Problems with children
Self harm
Separation/Divorce
Sexual problems
Sleep problems
Social problems
Stress
Spiritual concerns
Suicidal thoughts
Tired/Low energy
Trauma
Work Problems
Other_______________________________

How did you hear of our services? Name: ____________________________________

Friend____ Pastor____ Insurance____ Psychology Today ____ Web Site ____ Other ____________________