



PRESENTING ISSUES

Full Name: _____ **Age:** _____ **Marital Status:** _____ **Gender:** _____

What problems/struggles led you to seek counseling at this time?

When did these problems/struggles begin?

What changes do you hope counseling will help you achieve (your goals)?

How will you know when you've reached your goals?

Have you ever been in counseling before? Yes No

Was the experience Positive Negative Both Other: _____

Do you have any problems or questions related to any of the following if **YES** please explain:

Parenting Yes No _____

Step Parenting Yes No _____

Single Parenting Yes No _____

Custody Issues Yes No _____

Adoption Yes No _____

Abortion Yes No _____

Sexuality Yes No _____

Body Image Yes No _____

Relationships Yes No _____

Abuse: Yes No Physical Verbal Sexual _____

Communication Yes No _____

Spirituality Yes No _____

Finances Yes No _____

Legal Issues Yes No _____

Divorce/Separation Yes No _____

Employment Yes No _____

School Yes No _____

Alcohol or Drug Use Yes No _____

Gambling Yes No _____

Pornography Yes No _____

Internet Use Yes No _____

Any other areas of concern: _____

HEALTH HISTORY

Who referred you for treatment? _____

Would you like your therapist to communicate with the referral source listed above in order to coordinate your care? Yes No Please initial: _____

Who is your family/primary care physician outside the hospital? _____

Physician Phone Number: _____

Would you like your therapist to communicate with your family physician listed above in order to coordinate your care? Yes No Please Initial: _____

Please place a check mark in the box if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stomach or Digestion Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Nerve Damage/Weakness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Breast Removal | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Trouble with Bowels |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Recurring Headaches | <input type="checkbox"/> Trouble with Urination |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures | <input type="checkbox"/> Unusual discharge for Vagina
Or penis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shortness of Breath | Any other health concerns: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin Problems | |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chronic Fatigue Syndrome | |

Do you have coughing spells on a daily basis? Yes No

Do you bring anything up when you cough? Yes No

Do you smoke? Yes No if yes, how many packs per day? _____ How long? _____

Women Only: When was your last Menstrual Period? _____

Is there any chance that you are pregnant? Yes No Maybe

Current Medications/Dosage	For what conditions/diagnosis	Prescribing Physician
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Please use the back if you need additional space

Please list any medication and other allergies: _____

EATING HABITS

Are you on a special Diet? Yes No what type? _____

Are there any foods you can not tolerate? Yes No which ones? _____

Do you have any problems chewing or swallowing? Yes No

Have you gained weight in the past two (2) months? Yes No how much? _____

Have you lost weight in the past two (2) months? Yes No how much? _____

Do you have a poor appetite? Yes No

Have you had little or no food/liquid intake for more that 5 days? Yes No

Have you been drinking any special food supplements at home such as Ensure, Carnation Instant Breakfast, etc? Yes No _____

Have you had nausea, vomiting or diarrhea for more that the last 3 days? Yes No

Do you take laxatives or use a fiber supplement at home? Yes No

SLEEP HABITS

What time do you usually go to bed? _____
How long does it take you to fall asleep? _____
How many times do you wake up during the night? _____
What time do you get up in the morning? _____
How many naps do you take in a 24-hour period? _____
Any other concerns about your sleep? _____

On a scale of 1 – 10, how do you see you ability to function in your life right now? (circle)
Worst 1 2 3 4 5 6 7 8 9 10 Best

LIVING ARRANGEMENTS / ENVIRONMENT

Currently Reside: Alone Parent Spouse Friend Other: _____
 Children how many/ages: _____
Type of Residence: House Apartment Townhouse Dormitory Other: _____

RECREATION / EXERCISE

Do you follow a regular exercise routine? Yes No
Describe (what, how often, etc.): _____
What do you like to do in your spare time? Reading Gardening TV/Radio Sports
 Hunting/Fishing Outdoor activities Puzzles Other: _____

EDUCATION / VOCATIONAL TRAINING

Last year of school completed? _____ Degree earned? _____
Were you ever identified as having a learning disability? Yes No
Explain: _____
Do you have any specialized vocational or professional training? _____
Did any life circumstances interfere with you reaching your education goals? Yes No
Explain: _____

EMPLOYMENT HISTORY

What is your current employment status? Employed Full-Time Employed Part-Time
 Unemployed Homemaker Student Retired Disabled Other _____
If Employed: Job Title: _____ Duties: _____
Company Name: _____ Location: _____
Have you ever been fired or asked to resign? Yes No Explain: _____
Previous Employer: _____

LEGAL STATUS

Legal Problems/Charges: Include past history, current, and pending charges

Date	Describe	Outcome (include court dates)	Alcohol/Drug Related
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

MILITARY STATUS

Have you ever served in the military? Yes No Branch: _____

If yes, please answer the following:

How long did you serve? 6 months or less one (1) year or less 2 – 4 years

more than 4 years How many years? _____

Type of Discharge: Active General Honorable Retired Bad Conduct

Dishonorable Medical

Was alcohol or drug use involved in your discharge? Yes No

How? _____

Have you ever received psychiatric/chemical dependency services through military providers?

Yes No

Comments: _____

SPIRITUAL CONSIDERATIONS

Were you raised in a religious faith? Yes No

List: _____

Do you currently practice a religious faith? Yes No

List: _____

Is your spirituality important to you? Yes No

Describe what spirituality means to you: _____

CULTURAL INFLUENCES

Ethnicity: White African American Hispanic Asian Native American

Other: _____

Primary Language: _____

Were you raised outside the United States? Yes No

Comments: _____

EMERGENCY CONTACT PERSON

Name: _____ Relationship: _____ Phone: _____

Address: _____

Signature of person providing information

Date

If other than client, relationship