Name:		Phone/Cell:
Address:		City:
Zip:		Email:
Home Phone:		Safe To Leave a Message? **Yes** or **No**
Birthdate:		Gender:
Race:		Ethnicity:
Occupation:		Employer:
Job Title:		Length of Employment:
Religious Affiliation:		
Church (Currently Attending):		Pastor:
Physician:	Phone:	Date of Last Exam:
Psychiatrist:	Phone:	Date of Last Session:
Marital Status (Select One): ◯Single ◯Engaged ◯Married ◯Separated ◯Divorced ◯Remarried		
Education (Select One) ☐High School ☐GED ☐Associate ☐Bachelor ☐Graduate Major:		
Hobbies:		
Emergency Contact (Name , Phone, Relationship):		
Parent/ Guardian Name (minor client):		Spouse/Partners Name:
Were you raised by anyone other than your parents? If so please explain.		
Siblings (Name and Age)		
Children (Name and Age)		

Medical	
Ongoing Medical Concerns:	
Medications:	
Pertinent Legal Concerns	
Current:	
Previous:	
Military Service	
Dates of Service:	Branch:
Pay Grade:	Type of Discharge:
Relationships with Peers:	Relationships with Supervisors:
Work Satisfaction	
Are you satisfied with your current job?	
Daily Routine	
How is your Appetite?	Have you had recent changes in your appetite?
Have you experienced Recent Weight Gain or Loss?	How well do you sleep?
	Do you remain asleep?
Have you experienced changes in your sleep?	Do you fall asleep easily?

Have you experienced changes in your sleep pattern in the last six months?					
Describe your exercise habits?					
Condition	Past	Present Less than Six Months	Condition	Past	Present Less than Six Months
Mood High or Low			Frequent Loss of Temper		
Weight Loss/Gain			Acting Out Violence		
Appetite Changes			Frequent Residence Changes		
Cigarette Smoking			Frequent Employment Changes		
Tobacco Usage			Bed Wetting Past Age 6		
Irritability			Fire Setting Past Age 6		
Excessive Stress			Blaming Others Frequently		
Crying Spells			Lack of Sexual Desire		
Phobias or Fear			Spiritual Confusion		
Hallucinations			Thoughts of Suicide		
Confusion			Difficulty Reading		
Low Self-Esteem			Indecisiveness		
Compulsive Behaviors			Inability to Express Yourself		
Depression			Involvement with the Occult		
Extreme Nervousness			Difficulty Concentrating		
Lack of Motivation			Hearing Unseen Voices		
Anxiety			Use of Pornography		
Loss of Memory			Physical Abuse of Children		
Fantasizing			Sexual Abuse of Children		
Physical Abuse from Others			Physical Abuse of Others		
Insomnia			Excessive Sexual Activity		

Excessive Worries			Sexual Abuse from Others		

Drug and Alcohol Usage	
Are you currently taking drugs (other than medications or supplements)? **YES NO**	If yes, what drugs are using?
Do you drink Alcohol? **YES NO**	How Often Do you Drink?
How much do you drink?	Has Alcohol affected your ability to function within your family or at work?

Family History
Identify and Describe your primary female care giver, please provide some characteristics of this person?
Identify and Describe your primary male care giver, please provide some characteristics of this person?
How did your caregivers interact with each other while you were in the home?
Describe any problems between you and your siblings?
Is there a history of emotional or mental disorder or suicide within your family?
Is there a history of alcoholism, excessive alcohol or drug use within your family?

List any significant past trauma experienced by you or those close to you?

Religious History	
In what Faith were you raised?	What is your current affiliation or church?
Do you consider yourself a Christian? **YES☐ NO☐ UNSURE☐**	If yes, when did you become a Christian?
Has your relationship with God helped or hurt your ability to deal with your struggles?	
Do you practice spiritual disciplines?	If yes, how frequently?

Check if you have experienced the following	
☐ Death of a Spouse	☐ Death of a Child
☐ Death of a Father	☐ Death of a Mother
☐ Death of a Sister	☐ Death of a Brother
☐ Death of a Grandmother	☐ Death of a Grandfather
☐ Death of an Aunt or Uncle	☐ Suicide
☐ Miscarriage	☐ Abortion
☐ Adoption	☐ Infertility
☐ Bankruptcy	☐ Homelessness
☐ Career or Job Loss	☐ Divorce
Other trauma or tragedies:	

Briefly answer the following questions?
Identify and describe the problem you are currently experiencing.

How would your life be different if you were not experiencing this problem?
What have you done to resolve this problem?
What do you hope these counseling sessions will accomplish?

What immediate circumstances have led to you making an appointment to seek help?

Is there any other information you wish to provide that you feel would be beneficial to the counseling process?