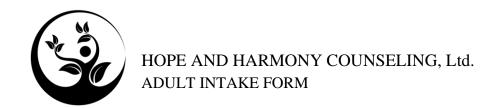


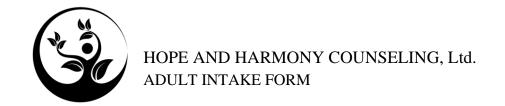
Please provide the following information and answer the questions below. Please note the information you provide here is protected by client/therapist confidentiality.

## **Client Contact Information:** Name: (First) (Middle Initial) (Last) Address: (City) (State, Zip) (Address) Home Phone number: May we leave a message? YES / NO Cell Phone number: \_\_\_\_\_May we leave a message? YES / NO Work Phone number: \_May we leave a message? YES / NO Home/Work number: May we leave a msg with 3rd party? YES / NO Email address: May we communicate by email?\* YES / NO \*Please note: Email correspondence is not considered to be a confidential medium of communication. Additional way to be contacted: Referred by:\_\_\_\_\_ **Emergency Contact Information:** (Who should we contact in case of an emergency?) Name:\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_ Cell Phone number: \_\_\_\_\_ Home Phone number: \_\_\_\_\_ Other relevant contact info: \*Please write any additional emergency contact information on the back of this sheet. **Physician Contact Information:** Name of Physician:\_\_\_\_\_\_ Phone Number:\_\_\_\_ Associated Hospital:\_\_\_\_\_ May we contact your physician: (Please note: Release of Information form must be signed) YES / NO \*Please write any additional physician contact information on the back of this sheet. Other Important Contact Information: (If you are under the care of a psychiatrist, reiki specialist, homeopath or other, please provide the contact information below.) Name of Professional: Phone Number: May we contact this person: (Please note: Release of Information form must be signed) YES / NO \*Please write any additional other important contact information on the back of this sheet.



Please provide the following information and answer briefly the questions below. This information will be discussed in depth during Intake. Please note: Information you provide here is protected as confidential.

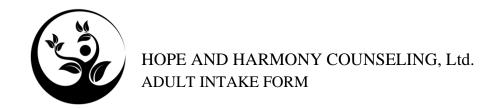
BR	IEFLY DESCRIBE YOUR REASON FOR SEEKING COUNSELING:					
	YSICAL AND MENTAL HEALTH:					
l.	How would you rate your <b>current physical health</b> ? (please circle)					
PoorUnsatisfactorySatisfactoryGoodVery Good						
2.	How would you rate your current mental health? (please circle)					
	PoorUnsatisfactorySatisfactoryGoodVery Good					
3.	Please check off any difficulties you are currently experiencing:					
	Grief/LossChronic Medical ProblemsEmployment Issues					
	Parenting IssuesLegal/Financial ProblemsRelationship Issues					
	Family Related IssuesReligious/Spiritual IssuesSexual/Intimacy Issues					
	Anxiety/DepressionCommunication/Trust IssuesCombat Related Issues					
	Other (Please Explain):	Yes / No				
1.	Have you previously received mental health services for these or other conditions?					
	If yes, please indicate dates, whether inpatient/outpatient, issues for which you were treated.					
5.	Are you currently taking any prescribed medication (psychiatric or other)?					
	If yes, please list current medications and dosage:					
6.	If not on medication, is a referral for a medication evaluation needed?	Yes / No				
SEL	.F CARE:					
1.	What kinds of things do you do currently to take care of yourself?					
2.	How would you describe your diet?					
3.	What activities do you enjoy?					
1.	s there anything additional that you would like me to know regarding your personal self-care that may help n therapy?					



## **FAMILY MENTAL HEALTH:**

Please indicate if there is a family history of any of the following. If yes, please indicate which family member(s) and briefly how it has affected you.

Ab	use: <b>Yes No</b>					
		es 🗆 No				
		] No				
		Behavior: 🗆 Yes 🗆 No				
Pos	st-Traumatic Stress:	□Yes □ No				
		No				
		□ No				
Sui	cide Attempt(s): □ <b>Y</b> €	es 🗆 No				
	CIOCULTURAL BACKO Are you currently ended to the second of		o know regarding thi	Yes / No s that may help in therapy?		
2.	Do you consider you	urself financially secure?		Yes / No		
	Is there anything additional that you would like me to know regarding this that may help in therapy?					
3.	How do you identify	y yourself spiritually/religiously				
	Is there anything additional that you would like me to know regarding this that may help in therapy?					
4.	How do you identify yourself with respect to your sexual orientation, gender identity, or gender expression?					
	Is there anything additional that you would like me to know regarding this that may help in therapy?					
5.	Relationship Status: (mark all that apply)					
	$\square$ Never Married	☐ Domestic Partnership	☐ Married	$\square$ Separated		
	☐ Divorced	☐ Widowed	□ Casual	☐ Committed		



6.	Do you have children? Yes / No
	If yes, how many and what ages?
	Is there anything additional that you would like me to know regarding this that may help in therapy?
7.	How do you identify yourself ethnically/culturally?
	Is there anything additional that you would like me to know regarding this that may help in therapy?
8.	Is there any additional information regarding yourself or your family that may be helpful for me to know?
<u> </u>	 HER:
1.	Describe your most supportive relationship (past and/or present):
2.	Reflecting on past experiences, what is an example of something you have overcome and how did you do it
3.	What did you learn about yourself from this experience?
4.	What would you like to accomplish from coming to therapy?
5.	List at least three personal characteristics you consider strengths:
CI:-	ent Signature Date