DATE:________________

INDIVIDUAL FORM

Name:____

Address______________________________________ City:______________ Zip________

Home Phone____________________________ E-mail____________________________________

Occupation____________________________ Employer__________________________________

Work Address____ Zip__________

W. Phone__________________ Cell/Pager____________________ E-mail________________

Birth Date____________________ Age________ Sex________ SS #:______________________

Who referred you to us?____

Please list Children: If no Children list Siblings	Age	Sex	SSN	Birthdate	Living at home Yes	No

Have you ever been married? Yes____ No____ If so, to whom and for how long? Also please give partners address and work phone or cell?

Are there any other persons living in your household? Yes_____ No_____ If yes, please give their name(s), ages, and their relationship to your family.

Are your parents living? If yes, please give their names, address(es), and telephone number(s). If no, give the name, address, and telephone of the nearest relative.

Mother Yes_____ No_____ Father Yes_____ No_____

BASIC HEALTH AND COUNSELING HISTORY

Good____ Fair____ Poor____ Date of last Physical Exam?________________________________

Name of Physician?____ Phone______________

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes, what? ______________________________________

____

____

Have you ever been hospitalized? Yes______ No_____ If so, for what?___________________

____

Do you drink alcohol? Yes____ No____ If yes, amount? ________________________________

Do you use any illegal drugs? Yes____ No____ If yes, what?__________________________

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what____

____

Have you had counseling in the past? Yes____ No____ If so, From:__________ To:__________

With whom?________________________________ For what?___________________________

____

RATE YOUR CURRENT MENTAL STATUS:

	G = Good	F = Fair	P = Poor	Comments
1. Memory/Short	G	F	P	
2. Memory/Long	G	F	P	
3. Insight/Judgement	G	F	P	
4. Attention	G	F	P	
5. Concentration	G	F	P	
6. Affect/Mood	G	F	P	
7. Eye Contact	G	F	P	
8. Body Movement	G	F	P	
9. Speech	G	F	P	
10. Impulse Control	G	F	P	

CURRENT REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

What would you like to see happen as a result of counseling?

The thing which concerns me the most right now is?

POLICY

A counseling session is normally 50 minutes. It is customary to pay your therapist after each session. A 24-hour cancellation notice is appreciated; otherwise the usual fee may be charged.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, or child abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I understand that I have the right to refuse treatment at any time.

Client Signature____

Psychotherapist Signature____