

Date: _____

Primary Client Contact Information

Name: _____ Nickname: _____

Parent/Guardian Name(s) (if applicable): _____

Date of Birth: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Please check next to your preferred phone number. If applicable, please indicate if phone numbers are for primary client or parent/guardian:

Mobile Phone: _____ Voice Message Ok

Home Phone: _____ Voice Message Ok

Work Phone: _____ Voice Message Ok

Other Phone: _____ Voice Message Ok

E-mail: _____

Please note: we will use your email address to remind you of upcoming appointments

Would you like to be included on our e-mail list for community workshops and events? Yes No

In Case of Emergency, Whom May We Contact?

Name: _____ Phone Number: _____

Relationship to you: _____

Please Complete If Client is Under 18 Years of Age:

Mother's Name: _____ **Date of Birth:** _____

Employer: _____ Primary Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____ **Date of Birth:** _____

Employer: _____ Primary Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Step-Father's Name: _____ **Date of Birth:** _____

Employer: _____ Primary Phone Number: _____

Step-Mother's Name: _____ **Date of Birth:** _____

Employer: _____ Primary Phone Number: _____

Siblings:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Background Information

Referral Information

Referred by: _____ Address: _____

May we thank them for their referral: Yes No

Counseling History

Are you involved in counseling now? Yes No

If yes, Individual Counseling Couple's Counseling Both

With whom: _____ Address: _____

Have you previously been in counseling: Yes No

If yes, Individual Counseling Couple's Counseling Both

With whom: _____ Address: _____

Education/Employment Background

Occupation (or indicate student): _____ Years of Education Completed: _____

Employer or School: _____ Highest Degree Attained: _____

Medical History

Physician and/or Medical Group: _____ Phone: _____

Office Address: _____

Estimated date of last physical exam: _____

Are you currently taking any medications: Yes No

If yes, please list:

_____ mg _____ Prescribed for: _____ By: _____

_____ mg _____ Prescribed for: _____ By: _____

_____ mg _____ Prescribed for: _____ By: _____

_____ mg _____ Prescribed for: _____ By: _____

Are you taking any vitamins or supplements: Yes No

If yes, please list: _____

Do you have any allergies: Yes No

If yes, please list: _____

Do you have any significant health problems: Yes No

If yes, please list: _____

Substance Use:

Number of alcoholic beverages you consume per week: ___none ___1-2 ___3-6 ___7-14 ___>14

Other mood altering substances used: ___none ___soda ___coffee ___nicotine ___chew ___marijuana ___other

Comment: _____

Have you ever tried to cut back or quit drinking/smoking? Yes No

Are you currently involved in a 12-step program? Yes No Which one? _____

Have you previously attended a 12-step program? Yes No Which one? _____

Comment: _____

Social Interactions and Outside Activities

Describe the quality of your friendships:

___awkward ___distant ___suffocating ___boring ___ok ___delightful ___other (describe:)

I have: ___few friends ___many friends I have: ___few interests ___many interests

Describe how you enjoy spending your time: _____

Do you wake up in the morning refreshed and energized? Yes No

How many hours do you sleep at night? ___less than 5 hrs ___6-8 hrs ___more than 8 hrs

Comment: _____

Family and Relationship History

Current relationship status: ___single ___married ___partners ___significant other ___separated ___divorced ___widow/widower

Current Spouse/Partner's Name: _____ Date of Birth: _____

Current Number of Years Together: _____ How many times have you been married? _____

How many committed relationships have you had in your life? _____

First (write name) _____ How old were you? _____

Second (write name) _____ How old were you? _____

Third (write name) _____ How old were you? _____

If currently divorced or single, number of years since break-up or divorce: _____

What were the reasons for your break-ups or divorces? Please include break-up/divorce dates: _____

If currently in a relationship: Describe the quality of your relationship with your partner:

___awkward ___distant ___suffocating ___boring ___ok ___delightful ___other (describe:)

Comment: _____

Are you currently involved in an extramarital affair? Yes No

Is your partner aware of this? Yes No Have there been other extramarital affairs? Yes No

Comment: _____

Is there abuse present in any of your relationship? Yes No

Type: ___physical ___verbal ___sexual ___emotional ___spiritual/religious ___drugs/alcohol ___other (describe:)

Comment: _____

Do you have children? If so, please list names and ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Therapeutic Goals

Please describe the problem or concern for which you are seeking help:

When were you first aware of this problem or concern?

How have you tried to address this problem or concern?

Please check any of the following you wish to address in counseling:

Personal

- manage stress and tension
- reduce sadness and depression
- decrease perfectionism
- reduce loneliness
- manage anger and temper
- increase enthusiasm and spontaneity
- reduce feelings of inferiority
- manage impulsive behaviors
- increase self-awareness
- overcome phobias
- develop more self-confidence
- reduce obsessive thoughts
- reduce worry and anxiety
- decrease shame and guilt
- explore sexual identity issues
- reduce panic attacks
- increase self-acceptance
- reduce feelings of hopelessness
- other _____

Interpersonal

- resolve arguments and conflicts
- improve relationship with spouse or partner
- improve relationship with parents, family or children
- improve relationship with in-laws and relatives
- improve sexual intimacy
- improve ability to cope with relationship breakup or divorce
- improve ability to relate with friends, roommates, co-workers, and others
- improve ability to express thoughts and feelings to others
- increase awareness of how behavior affects others
- improve parenting skills
- improve assertiveness skills
- explore step-family concerns
- increase emotional intimacy with loved ones
- other _____

Career Lifestyle

- clarify personal needs
- explore goals and values
- identify personal interest
- determine career direction
- reduce procrastination
- improve time management
- clarify life's meaning and purpose
- increase concentration
- clarify skills and abilities
- overcome performance anxiety
- increase self-discipline
- improve decision-making skills
- explore education direction
- manage finances
- clarify dreams and ambitions
- manage legal matters
- improve ability to relax and play
- other _____

Health

- overcome problems with drugs and/or alcohol
- reduce amount of caffeine in my diet
- reduce thoughts and potential of harming self/others
- overcome problems with smoking
- increase pep and energy
- address sexual abuse
- develop fitness program
- overcome problems with eating
- improve sleep
- explore sexual concerns
- find help for physical problems:
 - headaches, backaches, and other pains
 - stomach troubles
 - bowel troubles
 - allergies
 - other _____
- other _____

Agreements and Policies

Please review our insurance and payment agreements as well as our office and financial policies. If you would like a copy of any of these policies, please ask the front desk staff and we will provide one for you. If you have any questions please do not hesitate to ask.

Insurance Information

Subscriber: _____ Subscriber Date of Birth: _____

Address: _____ Phone: _____

Client relationship to subscriber: _____

Insurer: _____ ID Number: _____

Policy Group: _____ Plan Name: _____

Insurance Agreement

I have read and understand the insurance policy. I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits either to myself or the party who accepts assignment below.

Date

Print Client Name

Signature of client, parent or guardian

Payment Agreement

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I agree to pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection.

Date

Print Client Name

Print Name Person Responsible for Payment

Address City Zip

Signature of Person Responsible for Payment

I authorize my credit or debit card to be placed on file for future charges in accordance with the current office and financial policies.

Date

Print Client Name

Signature of Person Responsible for Payment

Office Policies

I have read the office policies and understand my rights as a client. I have been offered a copy of these office policies.

Date

Print Client Name

Signature of client, parent or guardian

Date

Signature of Therapist

If client is a minor, please review and sign reverse side of this form.

CONSENT FOR TREATMENT OF MINORS (UNDER 18 YEARS OF AGE)

NAME OF CLIENT

NAME OF PARENT

NAME OF PARENT

I am/We are the legal parent(s) of the above named client and give my/our permission to

COUNSELOR

to provide psychotherapy services to my/our child.

I am/We are aware that Jefferson Street Counseling & Consulting has no procedure for receiving after-hour emergency calls. If my/our child needs help immediately, I/we agree to contact our family physician, call 911, or go to the nearest hospital emergency room.

SIGNATURE OF PARENT

DATE

SIGNATURE OF PARENT

DATE