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 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