Today's Date:_____

CLIENT INFORMATION

First Name:_____ M.I.:___ Last:_____ Date of Birth: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: _____ Other phone: _____ May we leave a message? Y N

Email address: _____ May we send you emails for scheduling only? Y N

Your Employer: _____ Job title or type: _____

Emergency contact: _____ Relationship to you : _____

Emergency Contact Phone Numbers: _____

If using insurance, please provide the following:

Insurance Company (e.g., Blue Cross, Aetna) & state, if state other than Louisiana:_____

Policy or member ID # including letters: _____ Group # (if on card): _____

Deductible each year: _____ Deductible remaining this year:_____ Copay (specialist): _____

If someone else (e.g., spouse/parent) is the primary insurance holder, list the following for primary holder:

Primary's Name:_____ M.I.:__ Last:_____ Date of Birth: _____

Secondary Insurance Provider (if applicable)_____ Policy # (Member ID): _____

Current Healthcare Providers:

_____

_____

_____

Current Medications:

_____

_____

_____

Current or Past Medical Issues: _____

_____

_____

Please summarize:

Employment History: _____

Educational History: _____

Where you grew up, have lived: _____

Spiritual orientation if relevant for counseling: _____

Psychological Concerns (please check all that apply, and if possible, rank in order of importance):

Relationships with:
- __ Family
- __ Friends or coworkers
- __ Spouse/romantic

__ Anxiety
__ Depression
__ ADHD
__ Bipolar (Manic-Depressive)
__ Substance Abuse
__ Eating or body image

__ Health/physical/pain
__ Victim of Abuse
(Physical, Emotional, Sexual)

Harm to others:
- __ Thoughts of hurting others
- __ Assaults

Harm to self:
- __ Thoughts or plan to harm self
- __ Previous suicide attempts
- __ Other harm (self-inflicted wounds)

__ Financial troubles
__ Death, loss, grief
__ Career
__ Spiritual
__ Finding meaning
__ Increasing satisfaction
__ Increasing performance
(Work, hobbies, sports)
__ Healthy lifestyle
(food, fitness, relaxation)

Please describe any previous counseling, psychotherapy, or treatment with psychotropic medications including approximate dates, where you went, reasons for seeking treatment, and whether you benefitted.

_____

_____

Please check all that apply or have applied to any members of your family, even if not formally diagnosed:

___Anxiety
___Depression
___Alcohol Abuse
___Drug Abuse
___ADHD
___Bipolar Disorder
___Schizophrenia
___Eating Disorders
___Domestic Violence
___Emotional/Physical/Sexual Abuse
___Psychiatric Hospitalization
___Suicide
___Homicide
___Other problems

Healthy Lifestyle Questions

Caffeinated drinks (6 oz coffee)/day ___ Servings of sugar (all sources)/day _____

Alcoholic drinks/week _____ Cigarettes/day _____ Exercise sessions/week _____

Relaxation sessions (stretching, prayer, meditation, walking dog, reading to child, etc.)/week ___

Hobbies? What do you do for fun?_____

Passions? What do you love or have you loved in the past?_____

Please list names and ages of key people (family, children, romantic, friends):

_____ _____ _____

_____ _____ _____

Any Goals for Counseling:_____

Any Preferred Tasks or Method for Counseling:_____