

Name:			Date:
Name of spouse/partner, or parent if a minor:			
Date of birth:	Education level completed:	Marital Status:	Gender:
Home address:			
Home/Work Phone:	Email:	<b>How would you like appointment reminders sent?</b> <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <i>Please know phone and text are unsecure methods of communication.</i>	
Cell Phone:			
Current medications and dosage:			
Name of doctor:	Health insurance or EAP: Member ID #:	Primary insured: Primary insured birthdate:	
<b>Type of counseling you are seeking (check all that apply):</b> <input type="checkbox"/> Individual Adult <input type="checkbox"/> Child/Adolescent <input type="checkbox"/> Couples/Relationship <input type="checkbox"/> Family <input type="checkbox"/> Adjustment /stress <input type="checkbox"/> Anxiety <input type="checkbox"/> Anger Mgt. <input type="checkbox"/> Depression <input type="checkbox"/> Grief <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Career <input type="checkbox"/> Financial <input type="checkbox"/> Other:			
<b>Circle primary concern and check additional issues:</b> <input type="checkbox"/> Abandonment <input type="checkbox"/> Codependency <input type="checkbox"/> Gender identity <input type="checkbox"/> Self esteem <input type="checkbox"/> Anger <input type="checkbox"/> Depression <input type="checkbox"/> Grief <input type="checkbox"/> Self harming/cutting <input type="checkbox"/> Anxiety <input type="checkbox"/> Domestic violence <input type="checkbox"/> Health <input type="checkbox"/> Sex abuse <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Marital/Relationship <input type="checkbox"/> Suicidal ideation/attempt <input type="checkbox"/> Bipolar <input type="checkbox"/> Financial <input type="checkbox"/> PTSD <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____			
What prompted you to seek counseling? What would you like to achieve?			
Strengths: Weaknesses:		Recent stressors:	
Who referred you?	Previous and current counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:		
How do you prefer to participate in counseling? <input type="checkbox"/> in person <input type="checkbox"/> telephone <input type="checkbox"/> video <i>Telephone and video counseling must be approved by insurance and can only be done in Texas where I hold a license.</i>			
<b>Health:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor	<b>Psychosocial support:</b> <input type="checkbox"/> Family <input type="checkbox"/> Spouse/partner		
<b>Sleep:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Friend(s) <input type="checkbox"/> coworkers <input type="checkbox"/> 12-step program		
<b>Appetite:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> religious organization <input type="checkbox"/> pet <input type="checkbox"/> neighbors		
<b>Are you an emotional eater?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> other:		
<b>Family history:</b> <input type="checkbox"/> Anger <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> Domestic violence <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Sex abuse <input type="checkbox"/> Physical abuse <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Divorce <input type="checkbox"/> Alcohol/Drug abuse <input type="checkbox"/> Other:			
<b>Current substance use:</b> <input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Cigarettes <input type="checkbox"/> Marijuana <input type="checkbox"/> Other: _____ <input type="checkbox"/> DUI <input type="checkbox"/> Impairment at school or work <input type="checkbox"/> Use substances to relieve sadness, anger, boredom, insomnia			