Alliance Counseling

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in our first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them during your session. Case records are strictly confidential.

Today's Date: _____ Referred By_____

Name_____ Date of Birth_____

Address_____

City_____ Zip_____

Home Phone_____

Work Phone_____ E-mail (optional)_____

Age_____ SSN_____ Gender: F___ M___

Crime Victims Compensation Claim Number (if applicable)_____

Insurance Carrier_____

ID#_____

Group number_____

Insured's Date of Birth_____

Emergency contact_____ Relationship_____

Phone_____

Section II: MEDICAL HISTORY

Name and location of Physician_____

Date of your last physical exam: _____
Please list any significant illnesses, hospitalizations and injuries.

Have you ever had treatment by a psychiatrist, psychologist or counselor? Yes _____ No _____
Problem Where Therapist When? Helpful (Y/N)

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please state why you decided to come for counseling/therapy:

_____

Please state what you want to work on in therapy:

_____

How long has this been a problem for you?

_____

How would you estimate the severity of the problem? (Place "X" on the line below)

_____

Mild Moderate Serious Severe

What symptoms are related to this problem? Please check all that apply for you now:

__overeating __ restless __rapid heart rate __compulsive behaviors
__taking drugs __ depressed mood __sweating __fears/phobias
__odd behavior/thoughts __ crying __trembling or shaking __anxiety
__recent weight loss __ difficulty concentrating __shortness of breath __vomiting
__recent weight gain __ low motivation __muscle tension __distrust
__social withdrawal __ aggressive behavior __outbursts of temper __jumpy
__family emotional problems __ feelings of worthlessness __nightmares __dizziness
__chest pain __stomach problems __easily distracted __fatigue/loss of energy
__can't fall asleep __sleeping too much __decreased need for sleep __obsessions
__financial problems __problems with school __housing problems __relationship problems
__experienced a traumatic event __pain __drinking alcohol __ other: _____

If applicable, please describe any incidents or problems that may have triggered and/or been associated with this problem (e.g., physical or verbal abuse, relationship ending, etc.):

_____

In the past, what has been helpful to you in dealing with this problem?

_____

SECTION IV: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication, Dosage, M.D. Prescribing, Duration, Helpful (Y/N)

If applicable, amount of caffeinated beverages per day: coffee _____ soda _____ espresso_____ tea _____

If applicable, number of cigarettes smoked per day:_____

If applicable, how often do you use marijuana per week?_____

If applicable, other substances used

_____

Do you use alcohol or drugs to (check all that apply): Manage stress? __ To relax? __ To change mood? __ For sleep? __

SECTION V: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
Mother	_____	_____	_____	
Father	_____	_____	_____	
If applicable, Stepfather	_____	_____	_____	
Stepmother	_____	_____	_____	
Siblings	_____	_____	_____	
Siblings	_____	_____	_____	

Are your parents divorced? Yes _____ No ____

Have any members of your family had problems with:
drugs ___ alcohol ___ depression ___ anxiety ___ other mental illness ___ diabetes ___ epilepsy

Among your friends and family, whom do you count on for support?

I have received Alliance Counseling's statement of privacy practices and Therapist Disclosure form.

Signature Date