Reflections Professional counseling, LLC

Client's name: _____ Today's date: _____

Gender: __ F __ M Date of birth: ___/___/_____ Age: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (preferred): _____ Ok to leave a message? ____ Yes _____ No

Marital Status: Never married ____ Divorced _____ Unmarried, living together _____

Married _____ (# of times ____) Separated _____ Widowed _____

Emergency contact (name, number, relationship):

_____

Please state in your own words why you are seeking services at this time:

_____

_____

_____

_____

_____

How long has this problem been bothering you? _____

Are you required by a court of law to receive counseling services as part of a legal proceeding? If yes, please briefly explain

_____

_____

FAMILY INFORMATION

Relationship	Name	Age	Living (Y/N)?	Quality of Relationship
Mother				
Father				
Spouse				
Children				

Significant others (i.e. brothers, sisters, grandparents, step-relatives, half-relatives, etc):

Relationship	Name	Age	Living (Y/N)?	Quality of Relationship

Who all lives in your home currently? _____

CHILDHOOD/DEVELOPMENT

Please describe your childhood- who raised you, any special circumstances, any trauma, any history of child abuse (please specify if you were victim or perpetrator; and if victim, who perpetrator was), any other significant events?

_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL RELATIONSHIPS

Please check how you generally get along with other people: (Check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ____ Follower

___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

___ Other (Specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions or concerns? _____

Any current or prior history of being a sexual perpetrator? _____

SPIRITUALITY/RELIGION

How important to you are spiritual matters? ____ Not ___ A Little __ Some ___ Very

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into counseling? __ Yes __ No

If yes, describe: _____

LEGAL

Any current involvement in the legal system (traffic/civil/criminal cases)? __ Yes __ No

If yes, please describe and indicate any court dates and charges:

_____

Any current involvement with Child Protective Services? ___ Yes ___ No

If yes, please describe: _____

_____

Any past involvement in the legal system (traffic/civil/criminal cases)? ___ Yes ___ No

If yes, please describe: _____

_____

Have any legal problems involved drugs or alcohol? ___ Yes ___ No

If yes, please describe: _____

_____

EDUCATION

Are you currently enrolled in school? ___ Yes ___ No If yes, please explain: _____

_____

How far did you get in school? _____

Other training: _____

EMPLOYMENT

Are you currently employed? ___ Yes ___ No Where/What? _____

Currently: __ FT __ PT __ Temp __ Laid-off __ Disabled __ Retired __ Student

Any problems at work? __ Yes __ No. If yes, please describe: _____

_____

MILITARY

Any military experience? __ Yes __ No Any combat experience? __ Yes __ No

If yes to combat experience, where: _____

Branch: _____

Services dates: __/__/____ to __/__/____ Discharge type: _____

LEISURE

Please describe any hobbies or areas or interest – what do you do for fun/in your spare time? Have you had any recent changes in this area (for instance, spending less time doing these things or enjoying certain things less)? _____

_____
_____
_____
_____

MENTAL/PHYSICAL HEALTH

Have you ever received any mental health treatment before? __ Yes __ No

If so, what for, where, and when (including hospitalizations, outpatient, group, etc).___

_____
_____
_____

Have you ever had thought of self-harm or suicide? __ Yes __ No. If yes, please describe:

_____

_____

Do you currently have thoughts of suicide? __ Yes __ No.

Has anyone else in your family ever had any diagnosis or treatment for a mental illness, or any attempts of suicide? __ Yes __ No. If yes, please describe (who, what, when):_____

_____

_____

_____

How would you rate your current physical health? __ Excellent __ Good __ Fair __ Poor

Please circle any medical conditions you have:

AIDS	Headaches
Alcoholism	Hepatitis
Abdominal pain	High blood pressure
Abortion	Panic attacks
Allergies	Miscarriages
Anemia	Neurological disorders
Arthritis	Nausea
Asthma	STDs
Bed wetting	Sleeping disorders
Cancer	Stroke
Chest pain	Sexual problems
Chronic pain	Thyroid problems
Diabetes	Vision problems
Diarrhea	Vomiting
Dizziness	Other (describe):
Drug abuse	
Epilepsy	
Eating problems	
Fainting	
Fatigue	

Please describe any surgical procedures you have had: _____

_____

Are you taking any medications currently? __ Yes __ No. If yes, please describe: _____

_____

_____

_____

Do you take medications only as prescribed? __ Yes __ No

Do you have any history of trauma (i.e. traumatic experience, significant loss, abuse, sexual assault, domestic violence, chronic illness, severe accident, etc.)? __ Yes __ No

__ Victim __ Perptrator. If yes, please describe (details not necessary if they are difficult to discuss at this time): _____

_____

_____

_____

SUBSTANCE USE/ABUSE HISTORY

SUBSTANCE	AMOUNT	FREQUENCY	FIRST USE	LAST USE	COMMENTS
ALCOHOL					
COCAINE					
CRACK					
HEROIN					
OPIATES					
METH					
ECSTACY					
MARIJUANA					
PCP/LSD					
OTHER					

Have you ever been treated for a drug or alcohol problem? __ Yes __ No If yes, please describe: _____

_____

_____

Do you feel you have a substance abuse problem? __ Yes __ No

Are people close to you concerned about your substance use? __ Yes __ No

Does your substance use cause problems at work? __ Yes __ No

SYMPTOMS

Please circle the symptoms that occur more often than you would like them to:

Worry/tension	Fear	Social discomfort	Feelings of guilt	Phobia (unusual fears)
Panic	Upsetting thoughts	Flashbacks of traumatic event	Avoiding people/places	Nightmares
Loss in interest in pleasurable activities	Trouble managing relationships	Isolation and/or loneliness	Suicidal thoughts	Grief and/or feelings of loss
Trouble sleeping	Sleeping too much	Sadness, hopelessness	Low self-esteem	Normal tasks require too much effort
Anger	Irritability	Hostility	Euphoria	Mania
Racing thoughts	Mood fluctuation	Trouble concentrating	Obsessive thoughts	Compulsive or repetitive behaviors
Risky behavior	Impulsivity	Violence	Self-harm	Substance Abuse
Binge eating	Restrictive eating	Bingeing and purging	Sexual concerns	Trouble holding a job
Anxiety	Withdrawal			

Please describe these symptoms and any others you are experiencing:

_____
_____
_____
_____
_____
_____
_____

ADDITONAL INFORMATION

What do you feel are your strengths? _____

_____
_____
_____
_____
_____
_____

What do you feel are your weaknesses? _____

_____
_____
_____
_____
_____
_____

What would you like to accomplish out of your time in therapy? _____

_____
_____
_____
_____
_____
_____

_____ _____

Signature Date

Therapist's signature: _____ Date: _____