Fredericksburg Area Counseling, LLC

Client Registration Form

Date of First Appointment: _____ How did you learn about this practice? _____

Client Information:

First Name: _____ Middle Initial ____ Last Name_____

Preferred Name:_____

Date of Birth (MM/DD/YYYY _____ Age_____ Social Security #_____

Street Address: _____

City/State:_____ Zip Code:_____

Mobile Number: _____ Okay to text [ ] Yes [ ] No

Home Number: _____ May we leave a message? [ ] Yes [ ] No

Other Phone Number: _____ May we leave a message? [ ] Yes [ ] No

Email Address: _____ Do you use email communication? [ ] Yes [ ] No

Identified Gender as: [ ] Male [ ] Female [ ] _____

Race:_____ Languages:_____

Marital Status: [ ] Married [ ] Single [ ] Other

Employment Status: [ ] Student [ ] Part-time [ ] Full-time [ ] Unemployed Seeking Employment

[ ] Full-time Household Manager [ ] Disabled [ ] Other _____

Employer/School: _____ Years Employed/Current Grade_____

Job Title (if applicable):_____

Are you satisfied with your employment/school? If not, describe: _____

Highest Education level completed: [ ] grade 1-5 [ ] grade 6-8 [ ] grade 9-12 [ ] GED [ ] HS Diploma

[ ] some college [ ] undergraduate degree [ ] graduate degree or higher [ ] trade or certifications

When attending school are/where you in: [ ] Regular classes [ ] Special Education [ ] Advanced classes

[ ] Home School [ ] Alternative school **Were you ever:** [ ] Suspended [ ] Expelled

Give any additional important educational information (i.e. Did/do you like school? Have a learning disability?)

_____

Military Affiliation: [ ] None [ ] Retired [ ] Active [ ] Guard/Reserve [ ] Spouse/Child

Military Branch (if applicable): [ ] Army [ ] Navy [ ] Air Force [ ] Marine Corps {] Coast Guard

Deployments in support of combat operations: _____ Average time of Deployment_____

Discharge Date: _____ Type of Discharge_____

Other Affiliation: [ ] Homeland Security [ ] U.S. Coast Guard [ ] Other_____

Emergency Contact Information

Name: _____ Company:_____

Contact Type: [ ] PCP [ ] Emergency Contact [ ] Guardian [ ] Responsible Party of Billing

Relationship: _____ Date of Birth:_____

Street Address: _____

City/State:_____ Zip Code:_____

Mobile Number: _____ Okay to text [ ] Yes [ ] No

Home Number: _____ May we leave a message? [ ] Yes [ ] No

Other Phone Number: _____ May we leave a message? [ ] Yes [ ] No

Email Address: _____

Primary Insurance Information (If applicable):

Insurance Company: _____

Copay:_____ Deductible_____

Member ID:_____ Police Group Number:_____

Employer/School (Indicated on card)_____

Plan name:_____ Relationship to Client_____

Insured Party:

Subscriber Name: _____

Subscribers Date of Birth MM/DD/YYYY) _____ Social Security_____

Secondary Insurance Company if applicable:

Insurance Company: _____

Copay:_____ Deductible_____

Member ID:_____ Police Group Number:_____

Employer/School (Indicated on card)_____

Plan name:_____ Relationship to Client_____

Insured Party:

Subscriber Name: _____

Subscribers Date of Birth MM/DD/YYYY) _____ Social Security_____

Historical Information

Who is providing the history information? [ ] Client [ ] Parent/Guardian [ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

_____

_____

_____

_____

_____

_____

_____

_____

When did you first notice this problem and how long has it persisted? _____

_____

What stressors may have contributed to the current complaint or problem? _____

_____

_____

Summarize your goal(s) for counseling, i.e. what do you hope to accomplish: _____

_____

_____

_____

_____

_____

List your strengths, i.e. what are you good at, what do people like about you, that can help you achieve your counseling goal(s):	*List qualities about yourself or external factors you think might interfere with achieving you counseling goal(s):*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Check box if you *or someone else* sees this as a problem in your life:

☐	Depressed/Sad	☐	Feelings of shame or guilt
☐	Too high energy level	☐	Feelings of inadequacy/Low self-esteem
☐	Too low energy level	☐	Anxious/Nervous/Tense feelings
☐	Angry/Irritable	☐	Panic attacks
☐	Loss of interest in activities	☐	Racing or scrambled thoughts
☐	Difficulty enjoying things	☐	Bad or unwanted thoughts
☐	Crying spells	☐	Flashbacks/Nightmares
☐	Decreased motivation	☐	Muscle tensions, aches, etc.
☐	Withdrawing from people/Isolation	☐	Hearing voices others can't hear
☐	Mood Swings	☐	See shadows or images others cannot
☐	Black and white thinking/All or nothing	☐	Thoughts of running away
☐	Negative thinking	☐	Paranoid thoughts
☐	Change in weight or appetite	☐	Problem with perfectionism
☐	Sleep too much	☐	Rituals, i.e. counting things, washing hands, etc.
☐	Sleep too little	☐	Distorted body image
☐	Suicidal thoughts	☐	Feeling out of control eating, i.e. binge eating
☐	Self-harm/Cutting/Burning yourself	☐	Purging and/or use of laxatives
☐	Homicidal thoughts	☐	Purging and/or use of laxatives
☐	Poor concentration/Difficulty focusing	☐	Alcohol or substance abuse
☐	Feelings of hopelessness/Worthlessness	☐	Excessive use of internet, porn, gaming, etc.
☐	Intimate relationship problems	☐	Shoplifting
☐	Job problems	☐	Gambling
☐	Parent/Child relationship problems	☐	Other:_____

Are you currently experiencing thoughts of harming yourself? [ ] Yes [ ] No

Are you currently experiencing thoughts of harming someone else? [ ] Yes [ ] No

Previous Mental Health /Substance Abuse Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

If yes, what was the purpose? _____

If yes, what was helpful and/or what was not helpful? _____

Have you ever been hospitalized for psychiatric reasons? [ ] Yes [ ] No If yes, how many times _____

Last Hospitalization Date: _____ Length of stay: _____ Location: _____

Have you ever participated in Substance Abuse Treatment [ ] Yes [ ] No If yes, substance _____

[ ] Outpatient [ ] A/A or N/A [ ] Inpatient/Rehab [ ] Negative Legal Consequences

Are you still using? [ ] Yes [ ] No

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No If yes, please describe:

_____

Are you on probation? [ ] Yes [ ] No Name of PO and County: _____

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No If yes, please list any

Arrests/Convictions and Date of Arrests/Convictions and Outcome, i.e. Served time, Community Service,

Drug/Alcohol Treatment, etc: _____

_____

_____

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?

[ ] Yes [ ] No If yes, explain_____

Did you walk, talk, and read within developmental norms? [ ] Yes [ ] No

If no, explain: _____

Medical History

Please list any health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime and corresponding medications you currently take if applicable: _____

_____

Are you currently prescribed psychiatric medication? [ ] Yes [ ] No

If yes, who prescribes this medication? _____

What condition or symptoms is the medication intended to treat? _____

_____

Psychiatric Medication(s) & Dose: _____

_____

What has been your response to medication? _____

Have you experienced any head injuries? [ ] Yes [ ] No

If yes, did you lose consciousness? [ ] Yes [ ] No

Important Details: _____

Have you experienced convulsions or seizures? [ ] Yes [ ] No

Do you have any allergies? [ ] Yes [ ] No

Rate your current physical health: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

What are your current physical complaints, i.e. frequent headaches, stomach aches, etc.

_____

_____

What was the date of your last physical or routine health “check up?” _____

Do you have a primary care physician (PCP)? [ ] Yes [ ] No

PCP Name: _____

Address: _____Phone Number: _____

Please Sign for consent to contact PCP: _____

Family Background

Where were you born? _____

Family Psychiatric and Substance Abuse History (Condition/Relationship to Client): _____

_____

How would you describe your relationship with parental figures growing up and today (good, fair, poor, close, distant, etc.)? Mother: _____

Father: _____

Step-parent(s): _____

Other: _____

Social History

How would you describe your social support network? _____

Describe your relationship with peers and/or friends? _____

Describe your hobbies/interests: _____

Describe any cultural concerns: _____

Relationship History

Which best describes your marital status? [ ] Never Married [ ] Married [ ] Divorced [ ] Widowed

Number of Marriages ____ Number of Divorces _____

If you are currently married or in a long-term monogamous relationship, which best describes your relational satisfaction? [ ] Poor [ ] Fair [ ] Good [ ] Great

Briefly describe any concerns you might want to address associated with your committed relationship:

_____

_____

Children/Siblings (if a minor)

1. Name: _____
   Age: _____ Gender: _____
2. Name: _____
   Age: _____ Gender: _____
3. Name: _____
   Age: _____ Gender: _____
4. Name: _____
   Age: _____ Gender: _____
5. Name: _____
   Age: _____ Gender: _____
6. Name: _____
   Age: _____ Gender: _____

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No

Life Events Checklist

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate how it impacted you.

Event	Happened to me	Witnessed It	Learned about it	Not Sure	Doesn't Apply
Natural Disaster (flood, hurricane, tornado, earthquake, etc…)					
Fire or explosion					
Transportation accident (car, boat, train, plane, etc…)					
Serious accident at work, home or during recreational activity					
Exposure to toxic substance (dangerous chemicals)					
Physical assault (attacked, beaten up, hit, kicked, etc…)					
Assault with a weapon (shot, stabbed, threatened harm w/weapon)					
Sexual Assault					
Other unwanted or uncomfortable sexual experience					
Combat or exposure to a war-zone					
Captivity (kidnapped, abducted, held hostage, etc…)					
Life-threatening illness or injury					
Severe human suffering					
Sudden, violent death (homicide, suicide)					
Sudden, unexpected death of someone close to you					
Serious injury, harm, or death you caused to someone else					
Any other very stressful event or experience					

**Describe if you checked “other”: _____

Additional Information

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_____

_____

_____

_____

_____

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_____

_____

_____

Signature of Client_____ _____Date_____

For Minors

Signature of Parent/ Guardian _____ _____ _____Date_____

(1) Parent Name: _____Phone Number:_____

)2) Parent Name: _____ Phone Number: _____