*Hello! I look forward to meeting you and supporting you! Please fill these forms out so I can get to know you a little better.*

Legal Name: _____

Is there is a name or nickname you prefer for me to call you? _____

Please indicate your pronoun use: He/His She/Hers They/Them _____

Address: _____
House/Street City, State, Zip

Phone Numbers: primary phone _____ (circle) cell, home, work

*May I leave you a detailed message or send you a detailed text message at this number? Yes No*

secondary phone _____ (circle) cell, home, work

*May I leave you a detailed message or send you a detailed text message at this number? Yes No*

Email: _____

*May I send you an email at this email address? Yes No*

Emergency Contact: _____
Name Phone Number Relationship

## Demographics

Date of Birth: _____ Identified Gender(s): _____

Sexual Orientation: _____ Identified Ethnicity(ies): _____

Relationship Status/Type: _____

Are you a parent? *(furkids count too!)* _____

Are you currently employed? What type of work do you do? _____

Have you served in the military, or are you a spouse/child of a service member? _____

## Medical History

Do you have a Doctor? Name/Clinic: _____Phone Number: _____

When was the last time you were seen by a primary care or other medical provider? _____

Are you currently under medical care? Yes No

If yes, please inform: _____

_____

Do you experience chronic pain or discomfort? Yes No

If yes, please inform: _____

_____

Are you currently prescribed any medications, including psychiatric medications? Yes No

If yes, please list: _____

_____

Have you had previous counseling experiences (include mental health hospitalizations) Yes No

If yes, please list: _____

## Present Mental Health

Below is a list of common human struggles. Please circle all that apply to you.

| | | | |
|---|---|---|---|
| Anxiety | Self-Control | Parenting | Work Stress |
| Depression | Unhappiness | Body Image | School |
| Fears/Phobias | Relationships | Separation/Divorce | Trauma/PTSD |
| Suicidal Thoughts | Anger | Thought Patterns | Insomnia/Sleep |
| Suicidal Urges | Sexual Problems | Drug/Alcohol Use | LGBTQ |
| Cutting | Finances | Health Problems | Other: _____ |

Do you currently misuse medication, alcohol or drugs (legal and illegal)? Yes No Unsure

Are you currently experiencing a desire to harm yourself or others? Yes No Unsure

Do you feel safe from physical or emotional harm in your day to day life? Yes No Unsure

Are you satisfied with the relationships (including friends and family) in your life? Yes No Unsure

Are you satisfied with your current sexual experiences? Yes No Unsure

Briefly, what are you hoping to achieve from counseling?

_____

_____

_____

_____

_____

Is there anything important you want me to know about you or your situation?

_____

_____

_____

_____

_____

## Insurance (if using) *Have your insurance card and a government issued id card ready for copying. Thanks!*

Insurance Company: _____

Subscriber ID: _____ Plan Name: _____

If you are not the primary subscriber, complete the following:

Primary Subscriber's Name: _____

Their Date of Birth: _____ Relationship to you: Spouse Parent Domestic Partner Other

Their full address (if different than yours): _____