RAM Counseling Services
12801 E. 85th St. N. Unit 101, Owasso, OK 74055
Office: 918-927-0211

Client Demographic Information

Client Information:

Last Name: __________________________ First Name: ___________________ M.I.: ________

Birth date: _______________________ Age: ______________ Ethnicity: _________________

Address: ___________________________________ City/State: ______________ Zip:________

Cell Phone: ____________________________ Is it ok to for RAM to leave messages?_______

E-mail: ___________________________________ Is it OK for RAM to send email?_________

Spouse/ Next of Kin/ Partner (in case of emergency):

Last Name: __________________________ First Name: ____________________ M.I.: _______

Birth date: __________________________

Address: __________________________________ City/State: _____________ Zip:__________

Home Phone: ______________ Work Phone: ______________ Cell Phone: (   )_____________

Email:______________________________

I have received, read, and signed: The Client Contract Initials________________

Notice of Privacy Practices Initials______________

I consent and authorize RAM Counseling to provide my counseling services.

Client Printed Name ____

Client Signature ____

Date_____________________________

Parent/ Guardian/ Responsible Party Printed Name ________________________________

Parent/ Guardian/ Responsible Party Signature ____________________________________

Date _____________________________________

(For Therapist): DX:____________________________________

Fees:___________________________________

Note: Information on this page is provided to billing and accounting staff.

COUNSELING AND MENTAL HEALTH

How did you hear about RAM Counseling Services? ___________________________________

Reason for visit today: ____
____
____

What are your expectations and goals of our time together in counseling? __________________
____
____
____

For Clinician:
Goal____
Goal____
Goal____
Goal____
Goal____

Treatment Method:
Length of Treatment:
Insurance:

Have you had previous counseling? __________ If yes, please list with whom, reason, when
____
____
____

Have you ever been inpatient for mental health reasons or substance abuse? _________
If yes, when, where and why were you hospitalized?
____
____

What diagnoses of mental health issues have you received in the past?
____

If you have ever been prescribed psychotropic drugs please list the name and the dates that you used them.
____
____

Have you ever engaged in any self harm behaviors? If yes, describe and give ages.

____

Have you ever attempted suicide? Is yes, give methods and ages

____

Are you currently experiencing any suicidal thoughts? _________________________________

Do you have any family members with mental health or substance abuse issues? If so what is the relationship and what is the problem?

____

____

____

Do you use any type of alcohol or drugs? _________ If yes:

Substance used	Frequency/amt of use	Method of use	Last use	First use

Do you experience any type of negative consequences from your substance use including physical health, relationship, financial, occupational, mental issues, legal etc.?

____

____

____

Have you ever been in a 12 step program and when? ___________________________________

If you gamble, how frequently do you go and do you spend more than you intended to?

____

Is there any family history of substance abuse?

____

____

____

FAMILY OF ORIGIN

	Name	Occupation	Education	Health
Father				
Stepfather				
Mother				
Stepmother				

Please list the parents that were present in your life in childhood. ____________________________

What is the current marital status of parents? ____
____

Siblings in order of birth (please include yourself) and ages

____
____
____
____

Who lived in your home when you were growing up? If people in addition to those listed above please indicate relationship.

____
____

Was your home life

___ Outstanding ____ Normal ______Chaotic _____ Witnessed abuse ____Abusive to you

Explain ____
____

At what age did you leave home? ___________ Was your family supportive at this time?______

Why or why not?____
____

Any special circumstances during childhood?____
____

Any significant relationship issues when you were growing up either between you and someone else or between two other family members? ____
____
____

DEVELOPMENT

Do you know of any difficulties your mother experienced during her pregnancy with you?
____

What type of delivery did she have? ____

Describe any type of developmental delays as an infant or toddler ________________________
____

What type of grades did you make in school?_______________________________________

What activities were you involved in? ____
____

If you had any type of difficulties in school; please describe ___________________________
____

What childhood illnesses did you have? ____
____

What difficulties did you experience as a child?____________________________________
____

What significant accidents were you involved in? ___________________________________
____

If you experienced trauma, abuse, neglect; please describe ___________________________
____
____
____
____
____

How would you describe your social interactions as a child? ___________________________
____
____

Any behavior problems growing up? ____
____

Significant losses in your life. ____
____

CURRENT

Marital status: _____ single _____married ______ divorced ______widowed______ remarried
If married more than once, please list previous spouses and dates

____

Children and ages:
Living with you   Not living with you

____
____
____
____

Who else lives with you? ____

What people in your life are supportive of you? _____________________________________

Highest level of education that you have received. ___________________________________

Occupation ____

How long have you held this position?___________________

Difficulties or stresses of employment. ____
____

Spirituality that is important to you ____

Cultural issues that are important to you ____
____

Any legal problems past or present? __________ If yes, describe type and dates.
____
____

Describe any financial struggles. ____
____

Describe any personal conflicts or difficulties at this time. _______________________________
____

MEDICAL

Please list all medications you are currently taking:

Name of RX Reason for RX Length of time on RX Dr that prescribes

____

____

____

____

____

____

____

Name of primary care physician__________________________ Date last seen________________

Primary Care phone number_________________________

Name of psychiatrist _________________________________ Date last seen_________________

Psychiatrist phone number__________________________

Allergies of any kind____

____

Hospitalizations/ surgeries; type and date

____

____

____

General health at this time

Good__________ Fair _____________ Poor_______________

Any health concerns or negative lab reports? ____

____

____

History in father, mother, siblings of any health problems________________________________

____

____

____

TREATMENT PLAN SIGNATURE PAGE

Client response to treatment plan:

____

____

No response (Please indicate reason):

____

Parent response to treatment plan:

____

____

Client Signature:

____

Date: ___________________________________

Parent/Guardian Signature (Client under age 14):

____

Date: ___________________________________

Clinician Signature:

____

Date: _________________________________