5870 Highway 6 North, suite 320. Houston, TX 77084. Phone: 713-588-0410
MG@Lifecyclescounseling. com Fax: 713-955-0275

Life Cycles Counseling

Name: _____

If minor, name of parent(s)/guardian: _____

Address: _____

City: _____ Zip: _____

Primary phone number: _____ Alternate number: _____

E-mail: _____ Date of Birth: _____

Insurance (if any): _____ Policy Number: _____

How did you hear about Life Cycles Counseling?

Psychology Today ____ Good Therapy ____ Insurance Directory ____ Google Search ____ Google Ad ____ Yahoo/Bing Search ____ Yahoo/Bing Ad ____ Community Newsletter ____ Doctor/Psychiatrist ____ Friend ____ 211 directory ____ Other (please specify) ____

Briefly describe the reasons you seek counseling.

_____
_____
_____

Please describe some of your major stressors.

_____
_____
_____

Have you ever participated in counseling before? If so, how was your experience? What did you like/not like about the counselor?

_____
_____

Have you ever been diagnosed with a Mental Health Disorder (e.g. Depression, Bipolar Disorder, PTSD etc.)?

No ____ Yes (please list) _____

Are you taking any medications for any mental health issues?

No ____ Yes (please list) _____

_____

Please list any medical/health issues:

_____

What medications (if any) do you take for these health issues?

_____

Which drugs do you consume, if any, on an occasional or regular basis (including alcohol, but *not* prescription medication).

_____

What do you consider your major strengths and the best part of your life?

_____

_____

Briefly describe your current support system, and indicate the level of the support you are receiving from each one (for example: "Mom – great support, Brother – estranged, Spouse –up and down, etc.)

_____

_____

_____

Please list goals that you want to accomplish with counseling (don't worry, if you're not sure, the counselor will help you identify some goals in the sessions).

_____

_____

What is your daytime occupation?

Working full-time ____ Working part-time ____ Stay at home parent ____ Unemployed, but looking for work ____ Unemployed – don't need or want to work ____ Student ____ Retired ____ Disability ____ Military ____ Other (please specify) _____

Please read the following items carefully and put a checkmark on each one according to the following scoring system:

1 = Rarely/Never, 2 = Sometimes, 3 = Often/Frequently, 4 = All the time/nearly all the time.

Please rate the symptoms only as they have occurred during the last 12 months.

	1	2	3	4		1	2	3	4
Sadness	☐	☐	☐	☐	Difficulty motivating yourself	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Poor concentration	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Relationship distress	☐	☐	☐	☐
Feelings of guilt	☐	☐	☐	☐	Poor impulse control	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Auditory hallucinations	☐	☐	☐	☐
Feeling "numb"	☐	☐	☐	☐	Visual hallucinations	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐	Paranoia	☐	☐	☐	☐
Isolation	☐	☐	☐	☐	Feeling worthless	☐	☐	☐	☐
Perceiving rejection	☐	☐	☐	☐	Loss of interest in activities	☐	☐	☐	☐
Moodiness	☐	☐	☐	☐	Lack of energy	☐	☐	☐	☐
Blaming self	☐	☐	☐	☐	Poor personal hygiene	☐	☐	☐	☐
Elated/Happy	☐	☐	☐	☐	Impaired function (work, school)	☐	☐	☐	☐
Stressed	☐	☐	☐	☐	Can't get along with others	☐	☐	☐	☐
Poor appetite	☐	☐	☐	☐	Violent behavior	☐	☐	☐	☐
Eating problems	☐	☐	☐	☐	Panic attacks	☐	☐	☐	☐
Restless	☐	☐	☐	☐	Memory problems	☐	☐	☐	☐
Easily distracted	☐	☐	☐	☐	Loss of consciousness/blackouts	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐	Grieving the death of someone	☐	☐	☐	☐
Homicidal ideations	☐	☐	☐	☐	Flashbacks from trauma	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐	Nightmares	☐	☐	☐	☐
Self-harm/mutilation	☐	☐	☐	☐	Increased risk taking	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	Migraines/headaches	☐	☐	☐	☐
Body/muscle tension	☐	☐	☐	☐	Stomach problems	☐	☐	☐	☐
Decreased sex drive	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Poor body image	☐	☐	☐	☐	Unable to connect to people	☐	☐	☐	☐