Counseling Center for Women, LLC

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GENERAL INFORMATION

Client(s) Name ____ Date ____________

Parent/Guardian Name (if applicable) ____

Client's Date of Birth ________________________________ Gender: Male Female

Address ____

City _____________________________________ State _______ Zip _______________

Phone Number ____

Driver's License Number _________________________

Social Security Number __________________________

Employer ____

Employment Position __________________________ Work Number ________________

Education/Training ____

Spouse's Name ____

Spouse's Driver's License Number __________________________________

Spouse's Employer ____

Spouse's Position ____

Spouse's Education/Training ____

No. of Marriages ___________ No. of divorces _________ No. of children _________

Child's Name _________________________________ Date of Birth _______________

Child's Name _________________________________ Date of Birth _______________

Child's Name _________________________________ Date of Birth _______________

Child's Name _________________________________ Date of Birth _______________

Emergency Contact
Person _______________________________________ Phone # __________________

PHYSICAL HEALTH INFORMATION

List any physical health problems

1. Date of Onset:

2. Date of Onset:

3. Date of Onset:

4. Date of Onset:

5. Date of Onset:

MENTAL HEALTH INFORMATION

Reasons for seeking counseling: ____

____

Date of most recent illness/symptom(s) of issue: _________________

Have you previously had the same or similar symptom(s)? YES ________ NO ________
If yes, give first date: _______________

Hospitalization Dates Due to Current Illness/Symptom(s): __________________________
If unable to return to work, give date of last day at work _____________________
Is Current Condition Due to any of the following?

Auto Accident YES _______ NO ________
Other Accident YES _______ NO ________
Employment YES _______ NO ________

Name of Referring Provider: ____

If not referred by provider, how did you hear about CCW? __________________________

____

Name of Primary
Physician ____ Phone # ________________
Medications currently taking:

____ Dosage ____________________

____ Dosage ____________________

____ Dosage ____________________

____ Dosage ____________________

Family Mental Health Background

Is there any history of the following in the client's family? (Family includes parents, siblings, grandparents, and cousins)

Depression YES ________ NO ________ Family Member with Condition ______________

Anxiety YES _______ NO ________ Family Member with Condition ______________

Bi-polar YES _______ NO ________ Family Member with Condition ______________

Schizophrenia YES _______ NO ________ Family Member with Condition ______________

Drug Abuse YES _______ NO ________ Family Member with Condition ______________

Alcoholism YES _______ NO ________ Family Member with Condition _____________

Other ________________________________ Family Member with Condition ____________

Are you currently seeing a counselor, psychologist, psychiatrist, or other helping

professional? YES _______ NO ________

If yes, Name ____

If you have ever been hospitalized, please explain: ________________________________

____

Are you currently involved in any legal action? If so, please explain: _________________

____

Is there a recent life crisis that has prompted you to seek counseling at this time? If so,

please explain: ____

____

I understand that I am financially responsible for payment of charges at the time services are rendered. I acknowledge that I am voluntarily consenting to counseling and that no guarantees have been made as to the results of counseling.

Signature ____ Date __________________