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| **INITIAL VISIT FORM** |

Kris Gooding, LCSW

Please fill out the information below for your initial evaluation interview. This information will be kept strictly confidential ***unless released by you with written consent***.

**REFERRED BY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE**: \_\_\_\_\_\_\_ **TODAY’S** **DATE**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birthdate**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Drivers's Lic #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_

**Ph (C)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is it ok to contact you here? \_\_\_\_\_\_\_\_\_\_\_ Leave messages?\_\_\_\_\_\_\_

**Ph (H):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it ok to contact you here? \_\_\_\_\_\_\_\_\_\_\_ Leave messages?\_\_\_\_\_\_\_

**Ph (W):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it ok to contact you here? \_\_\_\_\_\_\_\_\_\_\_ Leave messages?\_\_\_\_\_\_\_

#### Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for payment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a Partner (or Spouse) you wish us to have on file?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No. of Children in Family:\_\_\_\_\_\_\_\_\_

**INSURANCE CO. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What State?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Their Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to You the Client** (Check one) SELF: \_\_\_\_\_\_ PARENT: \_\_\_\_\_\_\_

SPOUSE: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### PEOPLE LIVING WITH YOU RELATIONSHIP BIRTH DATE AGE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

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**Who should be contacted in an emergency?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Counseling - When and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems &

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Medical Conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NOTE: The information on the following pages is optional; however any information you are willing to share will greatly help your therapist in understanding past and present experiences and how those are related to your present concerns.**

**Please share your reason for seeking help:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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###### FAMILY INFORMATION

Brothers? \_\_\_\_\_\_\_\_ Sisters? \_\_\_\_\_\_\_\_\_ Deceased? \_\_\_\_\_\_\_\_\_

Both parents living? \_\_\_\_\_\_\_\_\_\_\_

Physical abuse to you/siblings? \_\_\_Yes \_\_\_\_ No.

Sexual abuse to you/siblings? \_\_\_Yes \_\_\_ No

#### Alcohol/drug abuse with mother? \_\_\_\_Yes \_\_\_ No.

#### Alcohol/drug abuse with father? \_\_\_ Yes\_\_\_ No

Family history of anxiety or depression? \_\_\_ Yes \_\_\_ No. If significant, please explain:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you share a close relationship with parents or siblings now? \_\_\_\_\_\_Yes \_\_\_\_\_\_ No

Would you like to say more about your family of origin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### ISSUES AND CONCERNS

**(circle those that relate to your reasons for seeking help)**

ageing aggression alcoholism ambition appearance boredom career children confusion

decision-making dependency distrust drug use education gambling guilt/shame health problems

impotence inferiority judgment legal matters leisure time loneliness lying marriage memory

parenting physical abuse sexuality suicidal thoughts

**MEDICAL AND HEALTH**

**(circle current and past conditions)**

alcoholism allergies amenorrhea arthritis cancer cardiac problems chest pain constipation Crohns disease diabetes diarrhea dizziness epilepsy fibromyalgia herpes high blood pressure hyperventilation hysterectomy indigestion infertility joint pain lump in throat lupus

memory problems menopause mood swings multiple sclerosis nightmares no motivation numbness P.M.S. poor concentration pregnancy restlessness substance abuse suicide attempt surgery thyroid problems tremors weight loss/gain

**EXERCISE/LEISURE/HOBBIES**

Do you exercise? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_ No Please describe: \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recreational activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hobbies and interests? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALCOHOL/DRUG HISTORY**

**(circle current and past use)**

alcohol amphetamines anti-anxiety meds antidepressants aspirin barbiturates blood pressure meds caffeine cigarettes cocaine/crack coffee/tea diabetes meds diuretics ecstasy heart meds laxatives marijuana sedatives sodas thyroid meds tranquilizers vitamins

# Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe current and/or past use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous treatment for drug use or dependency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CURRENT PROBLEMS OR SYMPTOMS** |

Please read each item below and determine which statement is true for you. Then place an “X” in the box to indicate how often you feel that statement applies to you.

|  |  |  |  |
| --- | --- | --- | --- |
| **DURING THE PAST MONTH OR SINCE THE LAST OFFICE VISIT…** | **None or a little of the**  **time** | **Some of the**  **time** | **Most or all of the**  **time** |
| 1. Wake up at night in the early morning and unable to return to sleep |  |  |  |
| 2. Very restless sleep |  |  |  |
| 3. Fatigue or loss of energy |  |  |  |
| 4. Decreased sex drive |  |  |  |
| 5. Unable to enjoy life; have lost a zest for life |  |  |  |
| 6. Have withdrawn from others |  |  |  |
| 7. Strong thoughts about suicide |  |  |  |
| 8. Loss of appetite |  |  |  |
| 9. Memory problem, forgetfulness, poor concentration |  |  |  |
| 10. Feel irritable or easily frustrated |  |  |  |
| 11. Feelings of sadness or hopeless-ness |  |  |  |
| 12. Sleeping a great deal |  |  |  |
| 13. Decreased need for sleep |  |  |  |
| 14. Increased sex drive |  |  |  |
| 15. Increased energy |  |  |  |
| 16. So happy/energetic, people describe me as “manic” |  |  |  |
| 17. Have trouble getting to sleep |  |  |  |
| 18. Sudden episodes of nervousness or panic |  |  |  |
| 19. Fear of losing self-control |  |  |  |
| 20. Palpitations or rapid heart beat |  |  |  |
| 21. Shortness of breath |  |  |  |
| 22. Feel tense or anxious all day |  |  |  |
| 23. Feel very anxious in social situations |  |  |  |
| 24. Have recurring, troubling thoughts, images or impulses that I can’t get out of my mind |  |  |  |
| 25. Repetitive behaviors- excessive hand washing, etc. |  |  |  |
| 26. Feel very confused about my thoughts |  |  |  |
| 27. Strange or bizarre thoughts |  |  |  |
| 28. Hallucinations/ voices or seeing things that aren’t there |  |  |  |
| 29. Peculiar experiences that others do not understand |  |  |  |
| 30. Feel ready to explode |  |  |  |
| 31. Thoughts about harming someone |  |  |  |
| 32. Excessive use of alcohol/drugs |  |  |  |
| 33. Unusual eating habits |  |  |  |

Weight Loss – How much in past month? \_\_\_\_\_\_\_\_ pounds

Weight Gain – How much in past month? \_\_\_\_\_\_\_\_ pounds

Have you been trying to diet? \_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_ no

In the past, I have tried to cut down on my use of alcohol or other drugs. \_\_\_\_\_\_\_\_ yes \_\_\_\_\_\_ no

My Current Medication List

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication name and strength | Why am I taking this medication? | How and when do I take this medication? | Who prescribed this medication? | When did you begin this medication? |
| ***Example****: Lisinopril 20 mg* | *High blood pressure* | *One tablet every morning* | *Dr. Johnson* | March 2005 |
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|  |  |  |  |  |

* Remember to include any nonprescription (over-the-counter) medications, vitamins and dietary supplements.