Fredericksburg Area Counseling, LLC

Client Registration Form / Returning Client

Date of First Appointment: _____ How did you learn about this practice? _____

Client Information:

First Name: _____ Middle Initial ____ Last Name_____

Preferred Name:_____

Date of Birth (MM/DD/YYYY _____ Age_____ Social Security #_____

Street Address: _____

City/State:_____ Zip Code:_____

Mobile Number: _____ Okay to text [ ] Yes [ ] No

Home Number: _____ May we leave a message? [ ] Yes [ ] No

Other Phone Number: _____ May we leave a message? [ ] Yes [ ] No

Email Address: _____ Do you use email communication? [ ] Yes [ ] No

Identified Gender as: [ ] Male [ ] Female [ ] _____

Race:_____ Languages:_____

Marital Status: [ ] Married [ ] Single [ ] Other

Employment Status: [ ] Student [ ] Part-time [ ] Full-time [ ] Unemployed Seeking Employment

[ ] Full-time Household Manager [ ] Disabled [ ] Other _____

Employer/School: _____ Years Employed/Current Grade_____

Job Title (if applicable):_____

Are you satisfied with your employment/school? If not, describe: _____

Highest Education level completed: [ ] grade 1-5 [ ] grade 6-8 [ ] grade 9-12 [ ] GED [ ] HS Diploma

[ ] some college [ ] undergraduate degree [ ] graduate degree or higher [ ] trade or certifications

When attending school are/where you in: [ ] Regular classes [ ] Special Education [ ] Advanced classes

[ ] Home School [ ] Alternative school **Were you ever:** [ ] Suspended [ ] Expelled

Give any additional important educational information (i.e. Did/do you like school? Have a learning disability?)

_____

Military Affiliation: [ ] None [ ] Retired [ ] Active [ ] Guard/Reserve [ ] Spouse/Child

Military Branch (if applicable): [ ] Army [ ] Navy [ ] Air Force [ ] Marine Corps {] Coast Guard

Deployments in support of combat operations: _____ Average time of Deployment_____

Discharge Date: _____ Type of Discharge_____

Other Affiliation: [ ] Homeland Security [ ] U.S. Coast Guard [ ] Other_____

Emergency Contact Information

Name: _____ Company:_____

Contact Type: [ ] PCP [ ] Emergency Contact [ ] Guardian [ ] Responsible Party of Billing

Relationship: _____ Date of Birth:_____

Street Address: _____

City/State:_____ Zip Code:_____

Mobile Number: _____ Okay to text [ ] Yes [ ] No

Home Number: _____ May we leave a message? [ ] Yes [ ] No

Other Phone Number: _____ May we leave a message? [ ] Yes [ ] No

Email Address: _____

Primary Insurance Information (If applicable):

Insurance Company: _____

Copay:_____ Deductible_____

Member ID:_____ Police Group Number:_____

Employer/School (Indicated on card)_____

Plan name:_____ Relationship to Client_____

Insured Party:

Subscriber Name: _____

Subscribers Date of Birth MM/DD/YYYY) _____ Social Security_____

Secondary Insurance Company if applicable:

Insurance Company: _____

Copay:_____ Deductible_____

Member ID:_____ Police Group Number:_____

Employer/School (Indicated on card)_____

Plan name:_____ Relationship to Client_____

Insured Party:

Subscriber Name: _____

Subscribers Date of Birth MM/DD/YYYY) _____ Social Security_____

Historical Information

Who is providing the history information? [ ] Client [ ] Parent/Guardian [ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

_____

_____

_____

_____

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_____

_____

_____

When did you first notice this problem and how long has it persisted? _____

_____

What stressors may have contributed to the current complaint or problem? _____

_____

_____

Summarize your goal(s) for counseling, i.e. what do you hope to accomplish: _____

_____

_____

_____

_____

_____

Check box if you *or someone else* sees this as a problem in your life:

☐	Depressed/Sad	☐	Feelings of shame or guilt
☐	Too high energy level	☐	Feelings of inadequacy/Low self-esteem
☐	Too low energy level	☐	Anxious/Nervous/Tense feelings
☐	Angry/Irritable	☐	Panic attacks
☐	Loss of interest in activities	☐	Racing or scrambled thoughts
☐	Difficulty enjoying things	☐	Bad or unwanted thoughts
☐	Crying spells	☐	Flashbacks/Nightmares
☐	Decreased motivation	☐	Muscle tensions, aches, etc.
☐	Withdrawing from people/Isolation	☐	Hearing voices others can't hear
☐	Mood Swings	☐	See shadows or images others cannot
☐	Black and white thinking/All or nothing	☐	Thoughts of running away
☐	Negative thinking	☐	Paranoid thoughts
☐	Change in weight or appetite	☐	Problem with perfectionism
☐	Sleep too much	☐	Rituals, i.e. counting things, washing hands, etc.
☐	Sleep too little	☐	Distorted body image
☐	Suicidal thoughts	☐	Feeling out of control eating, i.e. binge eating
☐	Self-harm/Cutting/Burning yourself	☐	Purging and/or use of laxatives
☐	Homicidal thoughts	☐	Purging and/or use of laxatives
☐	Poor concentration/Difficulty focusing	☐	Alcohol or substance abuse
☐	Feelings of hopelessness/Worthlessness	☐	Excessive use of internet, porn, gaming, etc.
☐	Intimate relationship problems	☐	Shoplifting
☐	Job problems	☐	Gambling
☐	Parent/Child relationship problems	☐	Other:_____

Are you currently experiencing thoughts of harming yourself? [ ] Yes [ ] No

Are you currently experiencing thoughts of harming someone else? [ ] Yes [ ] No

Previous Mental Health /Substance Abuse Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

If yes, what was the purpose? _____

If yes, what was helpful and/or what was not helpful? _____

Have you ever been hospitalized for psychiatric reasons? [ ] Yes [ ] No If yes, how many times _____

Last Hospitalization Date: _____ Length of stay: _____ Location: _____

Have you ever participated in Substance Abuse Treatment [ ] Yes [ ] No If yes, substance _____

[ ] Outpatient [ ] A/A or N/A [ ] Inpatient/Rehab [ ] Negative Legal Consequences

Are you still using? [ ] Yes [ ] No

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No If yes, please describe:

_____

Are you on probation? [ ] Yes [ ] No Name of PO and County: _____

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No If yes, please list any

Arrests/Convictions and Date of Arrests/Convictions and Outcome, i.e. Served time, Community Service,

Drug/Alcohol Treatment, etc: _____

_____

_____

****************************CHANGES IN HISTORY SINCE LAST VISIT***************************************

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?

[ ] Yes [ ] No If yes, explain_____

Did you walk, talk, and read within developmental norms? [ ] Yes [ ] No

If no, explain: _____

Medical History

Please list any health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime and corresponding medications you currently take if applicable: _____

_____

Are you currently prescribed psychiatric medication? [ ] Yes [ ] No

If yes, who prescribes this medication? _____

What condition or symptoms is the medication intended to treat? _____

_____

Psychiatric Medication(s) & Dose: _____

_____

What has been your response to medication? _____

Have you experienced any head injuries? [ ] Yes [ ] No

If yes, did you lose consciousness? [ ] Yes [ ] No

Important Details: _____

Have you experienced convulsions or seizures? [ ] Yes [ ] No

Do you have any allergies? [ ] Yes [ ] No

Rate your current physical health: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

What are your current physical complaints, i.e. frequent headaches, stomach aches, etc.

_____

_____

What was the date of your last physical or routine health "check up?" _____

Do you have a primary care physician (PCP)? [ ] Yes [ ] No

PCP Name: _____

Address: _____Phone Number: _____

Please Sign for consent to contact PCP: _____

Additional Information

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_____

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_____

Signature of Client_____ _____Date_____

For Minors

Signature of Parent/ Guardian _____ _____ _____Date_____

(1) Parent Name: _____Phone Number:_____

)2) Parent Name: _____ Phone Number: _____