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 #: _______________________________

Street 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: ___________________________

Person responsible for payment:____

Is there a Partner (or Spouse) you wish us to have on file?:
Name___________________________Ph #: _____________________________

Occupation: ____

No. of Children in Family:_________

HEALTH INSURANCE COMPANY- IF YOU WISH TO USE INSURANCE:

Name ________________________ What State?_____________________

POLICY #_______________________________________GROUP#_____________

Phone #: ____

Policy Holder name: ____________________Their Birth Date: ______

Relationship to You the Client (Check one) SELF: ______ PARENT: _______

SPOUSE: _____________

Policyholder Address (If different than client address)

____
____
____

PEOPLE LIVING WITH YOU RELATIONSHIP BIRTH DATE AGE

___________________________________/_________________________/____________
___/________

___________________________________/_________________________/____________
___/________

___________________________________/_________________________/____________
___/________

___________________________________/_________________________/____________
___/________

Who should be contacted in an emergency?

____

Phone: ___________________________ Relationship:
____

Previous Counseling - When and with whom?
____

____
____

____
____

Family Physician: ___________________________ Last Visit:
________________________ Problems & Treatment:
____
____

Last Physical Exam: _________________

Significant Medical Conditions:
____

____
__

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:

____
____
____
____

____

____

FAMILY INFORMATION

Brothers? _____________ Sisters?______ _________ Are any siblings 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:____

____

____

Did you experience any significant losses as a child? _______ Would you like to explain?

____

Did either of your parents leave the home for a significant amount of time (over a week) due to emergency, neglect, illness, rehabilitation, or other life stressor?______
Would you like to
explain?____

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?

____

Hobbies and interests?

____

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:

____

Previous treatment for drug use or dependency:

____

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