Andrea Johnson counseling

ADULT PERSONAL INVENTORY

Today's Date: _____ Whom may we thank for referring you to our office? _____

Client Name: _____ Birthdate: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Ph#: _____ Email Address:_____

Whom may we contact in case of emergency: Name: _____ Relationship: _____

Address: _____ City: _____ Phone #: _____

Name of Insurance: _____ Member/Policy/Subscriber ID#: _____

Group #: _____ Name of Insured: _____ Birthdate: _____

Describe your current problem symptoms for which you are seeking counseling at this time or any significant events that recently occurred that prompted you to seek counseling at this time:

_____

_____

_____

Have you had counseling before? ☐ Yes ☐ No If yes, list name of therapist, date of service, and reason for counseling:_____

_____

Have you ever been tested by a psychologist? ☐ Yes ☐ No If yes, when and reason why: _____

_____

Have you ever been in a psychiatric hospital? ☐ Yes ☐ No Date(s): _____

Reason:_____

_____

When was the last time you had thoughts to harm yourself? _____

Last time you self-harmed? _____

Are you currently taking psychotropic medication? ☐ Yes ☐ No If yes, please list medications and dosages:

_____

_____

Name of Psychiatrist: _____ Phone#_____ Fax #_____

HEALTH INFORMATION:

Rate your current health: ☐ Very good ☐ Good ☐ Average ☐ Poor

Are you currently being treated for any medical conditions? ☐ Yes ☐ No If Yes, please explain:

_____

Do you have any chronic illnesses, genetic illnesses, allergies, or handicaps? ☐ Yes ☐ No If Yes, please explain:

_____

Are you currently taking medication? ☐ Yes ☐ No If yes, please list medications and dosages:

_____

_____

Name of Primary Physician: _____ Phone#_____ Fax#_____

RELATIONSHIP/MARRIAGE INFORMATION:

☐ Single ☐ Dating ☐ Married ☐ Live with Partner ☐ Divorced ☐ Separated

Name of partner: _____Length of current relationship: _____

Number of previous marriages and length married: _____

Reasons for termination of previous marriages: _____

Number of children: _____ Ages of children: _____

Who do you identify as your support system? _____

_____

Who all currently lives in your home:

1. Name: _____ Relationship: _____ Age: _____
2. Name: _____ Relationship:_____ Age: _____
3. Name: _____ Relationship:_____ Age: _____
4. Name:_____ Relationship: _____ Age: _____

FAMILY BACKGROUND INFORMATION:

List your caretakers as a child and their relationship to you. If different from your natural parents, please explain:

_____

_____

Were your parents divorced? ☐ Yes ☐ No If yes, what was your age at the time? _____

List the number of siblings and your place in the family (youngest to oldest):

_____

_____

ADULT PERSONAL INVENTORY

As a child, was your environment consistent or did you move around frequently? Please explain:

_____

Were your parents/caretakers involved in spousal abuse? ☐ Yes ☐ No If yes, please describe the type of violence that occurred and the frequency:

_____

_____

Please indicate if any family member has a history of:

☐ Depression ☐ Anxiety ☐ Bi-Polar ☐ Schizophrenia ☐ Eating Disorder
☐ Drug Addiction ☐ Alcoholism ☐ PTSD ☐ Undiagnosed/Unknown ☐ None

Have you ever been abused? ☐ Emotional ☐ Verbal ☐ Physical ☐ Sexual ☐ None

How old were you and who was the abuser or perpetrator?

_____

_____

At what age did you leave home? _____ ☐ Marriage ☐ School ☐ Work ☐ Other

Level of Education? ☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Advanced Degree

Current Job: _____ How long have you been at your current Job? _____

Do you drink alcohol? ☐ Yes ☐ Daily ☐ Weekly ☐ Only on Special Occasions ☐ No

Have you ever been arrested? ☐ Yes ☐ No If yes, please explain:

_____

_____

Do you have any current open legal cases? ☐ Yes ☐ No If yes, please explain:

_____

_____

I authorize Andrea Johnson LPC, NCC to release any information necessary to expedite insurance claims. I authorize payment to Andrea Johnson LPC, NCC for services described on submitted claim forms. I understand that I am responsible for payment of services, regardless of insurance coverage. I also understand that I am responsible for any charges incurred if I fail to cancel a scheduled appointment without 24 hours advance notice.

_____

Signature of Client Date

Please check all that currently apply to you:

- Abuse-emotional
- Abuse-neglect
- Abuse-physical
- Abuse-sexual
- Aggression
- Alcohol
- Anger
- Anxiety
- Arguing
- Attention problems
- Caffeine
- Career concerns
- Childhood issues (your own childhood)
- Children-care
- Children-custody
- Children-management
- Choices I have made
- Codependence
- Compulsive spending
- Concentration problems
- Confusion
- Crying
- Deaths
- Debt
- Decision making
- Decreased energy
- Delusions (false ideas)
- Dependence
- Depression
- Distracted
- Divorce
- Drugs
- Eating-making myself vomit
- Eating-overeating
- Eating-under eating
- Emptiness
- Excessively worried
- Failure
- Fatigue
- Fears
- Financial problems
- Friendship problems
- Gambling
- Grieving
- Guilt
- Headaches
- Health
- Hopeless
- Hostility
- Impulsive spending
- Impulsiveness
- Indecision
- Inferiority feelings
- Inhibitions
- Interpersonal conflicts
- Irresponsibility
- Irritability
- Judgment problems
- Laziness
- Legal matters
- Loneliness
- Loss of control
- Low frustration tolerance
- Marital conflict
- Marital infidelity/affairs
- Medical Concerns
- Mood Swings
- Nicotine
- Obsessions
- Outbursts
- Oversensitive
- Overwhelmed
- Panic/Anxiety attacks
- Parenting
- Paranoid
- Perfectionism
- Phobias
- Physical pain
- Relationship problems
- Re-marriage
- Sadness
- Self cutting
- Self control
- Self-esteem
- Separation
- Sexual conflicts
- Shyness
- Sleep-nightmares
- Step-parenting
- Stress
- Suicidal thoughts/prior attempts
- Temper problems
- Violence
- Weight and diet issues
- Withdrawal, isolating self
- Worthlessness

Any other concerns? _____

_____

_____