MELONIE GALE ~ MA LMFT, LPCC, LMHC, NCC
Licensed Marriage Family Therapist #46352
Licensed Professional Clinical Counselor #174
Licensed Mental Health Counselor #LH00003656
National Certified Counselor #56037
(858) 429-8999 melgale@msn.com
www.melgalecounseling.com

Personal Information (Please Print Clearly)

*Name:*_____*Date:*_____

*Address:*_____

City/State/Zip: _____

Email address: _____

*Cell-Home-Phone:*_____ *Work-Phone:*_____

*SS#*_____ *Date of Birth:* _____

*Employer:*_____

*Position:*_____ *How long at this position?* _____

In Case of Emergency, please notify: _____

Relationship: _____*Phone:*_____

*Referred By:*_____

Primary Health Insurance: ***(I will need to make a copy of your insurance card prior to first session)***

*Behavioral Health Insurance Company:*_____

Primary Policy Holder & your relationship: _____

*Primary I.D.#:*_____ *Employer of Primary:*_____

*Primary Policy Holder Date of Birth:*_____ *Primary Policy Holder SS#*_____

*Total Mental Health Outpatient Sessions Authorized:*_____ *Co-payment Amount* _____

Medical Information:

Current Status of Health: __*Excellent* __*Good* __*Fair* __*Poor*

If you are currently under a physician's care, please complete the following:

*Name:*_____*Phone:*_____

*Reason:*_____

Your Primary Care Physician, if other than previously stated:

*Name:*_____ *Phone:*_____

*Address:*_____

If you are currently taking any prescription medications, please List below:

_____

_____

Counseling Problem & Goals:

Please describe the problem(s) for which you are seeking counseling:

How long has this been a problem?

What do you hope to obtain from counseling?

Have you had counseling in the past? How long ago?

If so, Briefly describe the counseling your received in the past and if it was helpful?

Please list the names of your current spouse/partner and length of relationship:

Please list the names and ages of any children you have or are living with you currently:

Is there anything else you wish me to know prior to our working together?

CURRENT SYMPTOMS

Please indicate below any of the following you are now experiencing or within the last two months:

1= Mild 2= Moderate 3= Severe

If you have experienced any of the following in the past (more than two months ago) Put a "P"

__ *Difficulty getting to sleep*

__ *Difficulty staying asleep*

__ *Excessive Sleeping*

__ *Feelings of sadness*

__ *Feelings of emptiness*

__ *Lack of interest in things once enjoyed*

__ *Significant weight loss or gain*

__ *Feeling of worthlessness*

__ *Increase/Decrease of appetite*

__ *Feeling of excessive guilt*

__ *Crying easily or frequently*

__ *Easily angered, irritable*

__ *Difficulty concentrating*

__ *Unusual indecisiveness*

__ *Recurrent thoughts of death*

__ *Plan to commit suicide*

__ *Suicide attempt*

__ *Feelings of helplessness*

__ *Tearfulness*

__ *Difficulty controlling anger*

__ *Sudden pounding of heart*

__ *Sudden sweating*

__ *Sudden trembling or shaking*

__ *Sudden feeling of shortness of breath*

__ *Difficulty controlling drinking alcohol*

__ *Difficulty controlling drug use*

__ *Difficulty controlling gambling*

__ *Difficulty controlling spending money*

__ *Anorexia*

__ *Bulimia*

__ *Compulsive overeating*

__ *Very strong startle response*

__ *Excessive Fears*

__ *Difficulty expressing anger*

__ *Sudden decreased need for sleep*

__ *Pressure to keep talking*

__ *Thoughts racing*

__ *Easily Distracted*

__ *Increased need to get things done*

__ *Recurrent & persistent intrusive thoughts*

__ *Repetitive behaviors which are difficult to stop*

__ *Excessive worries & anxieties*

__ *Fear of losing control or going crazy*

__ *Excessive Nightmares*

__ *Fear of socializing with people*

__ *Sudden numbness or tingling*

__ *Sudden felling of dizziness*

Client Signature **Date**

RELATIONSHIPS:

Please indicate any significant difficulties you are presently experiencing, or have experienced in the past by checking the appropriate responses

	Present Problems	*Past Problems*
Current marriage or other intimate relationship	__	__
Prior marriage or other intimate relationship	__	__
Relationship with Son/Daughter	__	__
Relationship with Stepson/Stepdaughter	__	__
Relationship with Parent	__	__
Relationship with Brother/Sister	__	__
Relationship with Step parent	__	__
Relationship with Boss	__	__
Relationship with co-workers	__	__
Relationship with Close Friend	__	__

Client Signature **Date**