ALLIED: ADULT FACT REGISTRATION FORM Page 1

NAME_____ **DATE**_____

The Adult Treatment Agreement plus this Adult Fact Registration and the Adult Personal Registration must be scanned, signed and emailed to Dr. Austin (draustinchandler@alliedcounseling.com) at the Allied Counseling Greensboro Corporate Headquarters in advance of your first appointment. When these 3 signed forms have been sent, you can call the Allied Counseling Greensboro Corporate Headquarters (1-800-212-2604) to be sure they have all been received and we will help you schedule your first appointment. Please feel free to call the Greensboro Corporate Office if you have any questions when completing these forms or want to schedule another appointment once you have registered. Before Child or Adolescent Counseling can begin, both parents must complete, sign and email the above 3 forms plus the Child & Adolescent Fact Registration to Dr. Austin at Allied Counseling Headquarters in Greensboro. We try to return all office calls & emails within 24 hours.

HOW DID YOU HEAR ABOUT DR. AUSTIN OR ALLIED COUNSELING?

Internet search: (Specify Site or Sites): _____ _____

Advertisement: (Where): _____**Referred by family/friend/doctor:(Name)** _____

Other: _____

PERSONAL INFORMATION:

Name: _____ _____ _____

First **Middle** **Last**

Birth Date: ___/___/____ **Age:** _____

Address _____

(Number & Street) **(City, State)** **(Zip Code)**

Mobile # (_____) _____ **May we leave a message? ☐Yes ☐No**

Home # (_____) _____ **May we leave a message? ☐Yes ☐No**

Email Address: _____@_____

EMERGENCY CONTACT:

_____ (_____)_____ _____

Name **Phone** **Relationship to You**

ROMANTIC/SEXUAL ORIENTATION:

Heterosexual/Straight____ **Gay/Lesbian**_____ **Bisexual**_____

Questioning (Not Sure) _____

Transgender___

RELATIONSHIP STATUS:

Never Married_____ **Partnered**_____ **Married**_____

Widowed_____

Separated_____ **Divorced**_____

No Relationship now (how long)? _____ **Would like a Relationship: Yes**____ **No**____

Name of Significant Other (if any): _____ **How Long Have You Been Together/Married?**

_____

Relationship Quality: Poor/Unsatisfactory_____ **Satisfactory**____ **Good**_____ **Very Good**_____

No relationship now (how long? ___ **Do You Want a Relationship? Yes**__ **No** __

NAME_____ DATE _____

Number of Children (if any): _____ First Names & Ages_____

_____

EDUCATION/EMPLOYMENT HISTORY:

Years of Eeducation completed: High School (Name & Location) _____

Two Year College Degree: (Specify Subject & School) _____

Four Years College Degree: (Specify Subject & School) _____

Master's Degree: (Specify Subject & School) _____

Terminal Degree: (Specify Subject & University) _____

Current employer: _____

Job Title: _____

Job Description (Briefly Explain What You Do) _____

Is there anything stressful about your current job? (please explain) _____

GENERAL HEALTH:

Rate your physical health at present:

Poor/Unsatisfactory_____ Satisfactory_____ Good_____ Very good_____

List any physical health problems or injuries: (give details and dates when needed):

_____

_____

List prescription medicines and non-prescription medicines you take regularly & include vitamins.

Are you currently receiving, or previously received, any mental health psychiatric services, professional counseling or psychotherapy services? Yes_____ No _____

Name & Locations of Mental Health Professionals seen: _____

Dates & Length of Time Seen: _____

Do you or anyone in your family have ADHD or ADD? Yes___ No___ Do think you or anyone in your family may have ADHD or ADD but have not been diagnosed by a doctor? Yes__ No___ (Explain)

_____

Do you consider yourself to be religious or spiritual? Yes___ No____

If yes, please briefly describe your religious or spiritual beliefs:

_____

_____

NAME: _____ DATE:

FOCUSED HEALTH ISSUES:

Do you currently have, or ever had, Any of the following problems? Anxiety _ Chronic Worry _

Nervousness Social Fears Panic Attacks Phobias _

If Yes, please tell how long you have been having each of the above problems and which one bothers you most?

Do you have any chronic physical pain? Yes? No?

If Yes, please describe pain location, intensity, time of day most painful plus length of time you have had the pain at each specific location.

___

Do you currently have or ever had any of the following issues: Depression Unhappiness

Little Energy Grief Hopelessness Anger Agitation/Frustration

If Yes, please describe how long you have had each of the above problems and which one or one's bothers you the most?

Have you ever been the victim of: Physical Abuse? Mental Abuse? Unwanted Sexual Advances? If yes, when, how long and by Whom?

HEALTH HABITS & HEALTH ROUTINES:

Weekly, how often do you drink alcohol or beer? Never 1-3 Times___ 4-6 Times 7 Times or more

How often do you engage in reactional drug use? Never Daily Weekly Monthly

Do you think you currently have or ever had a drug or alcohol problem?

Please rate your current sleep quality: Poor/Unsatisfactory Barely Satisfactory Good Very Good

Number of hours you usually sleep a night? _ Is that enough for you? Yes? No??_

If no, what is preventing you from getting the quality and amount of sleep you need? Explain:

How many times a week do you exercise? Never 1-3 Times 4 Times or more

If none, what is preventing you from exercising to help maintain your health? Explain:

Do you currently have, or ever had, any problems with eating patterns or controlling your weight? Yes? ___ No? If yes, please tell when and how long plus explain.

LOOKING AHEAD:

What do you consider your major strength? Explain:

_____

NAME DATE:

What do you consider your major weakness? Explain:

What are the two major stressors in your life now?

What are your two major goals for personal counseling or personal life success coaching?

FAMILY MENTAL HEALTH HISTORY OVERVIEW:

In the section below please circle or underline every problem if there is a family member with that problem. If yes, also write the family members relationship to you to the right side of the problem. For example, you might write; self, father, mother, grandmother, uncle, cousin, etc.

Relative's Name:

Alcohol/Substance Abuse:

Anxiety/Phobias/ Social Fears;

Aggressive or Explosive Behavior:

Depression:

Bipolar Disorder/Major Mood Swings:

Domestic Violence:

Eating Disorders:

Obesity:

Obsessive Compulsive Behavior:

Schizophrenia:

Suicide Attempts

Serious Or Chronic Illness:

Major Financial Trouble/Bankruptcy:

Had Major Legal Problems:

Experienced Separation/Divorce:

Experienced The Death Of A Family Member Or Friend (Grief):