Connections Women's Group
Tamara McFarland, MS, LPC, RPT
Karen Stone, MS, LMFT, LCDC

860 Hebron Parkway Suite 803, Lewisville TX 75057 469-867-2240

GENERAL INFORMATION

Date:_____

Name:_____

Referred by:_____

Date of Birth:_____Age:_____Gender: M F

Home Address:_____
Street City Zip

Home Phone#:_____Cell #:_____

Work Phone#: _____ May we contact you at work? Y N

May we leave you a message? Home Phone_____Cell phone:_____Work Phone:_____

Email address:_____

Emergency Contact:_____Phone#:_____
(Signature on this document indicates consent to contact this person in case of an emergency)

Primary Care Physician:_____Date Last Seen:_____

Current diagnosis or medical concerns:_____

_____

Please list all medications: _____

_____

Briefly describe why you are seeking counseling: _____

_____

How would you rate the intensity of the problem or concern?

(1 being not intense 10 being very intense)

1 2 3 4 5 6 7 8 9 10

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Past Counseling History:

Date:	Length of Service	Agency & Therapist
_____	_____	_____
_____	_____	_____

Primary Household Information

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any concerning sleeping or eating habits: _____

_____

_____

Have you experienced any traumatic situations? Y N If yes, please explain:

_____

_____

_____

Have you ever thought about hurting yourself or another person? Y N

Please describe: _____

_____

_____

History of medication, alcohol or illegal drug use or dependence: Y N

_____

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Please check any past, present, or anticipated circumstances within the family or by family members?

☐ Divorce _____

☐ Serious Illness_____

☐ Relocations _____

☐ Physical or Sexual Abuse _____

☐ Grief or significant loss_____

☐ ADHD or ADD _____

☐ Depression _____

☐ Psychiatric Disorder _____

☐ Alcohol or Drug Use _____

☐ Attempted or completed suicide _____

☐ Eating Disorder _____

☐ Legal Problems _____

☐ Unemployment or High Job Stress _____

Other helpful information: _____

_____

_____

_____

_____

Client Signature:_____Date:_____