

Name: \_\_\_\_\_ Today's Date:     /     / \_\_\_\_\_

Date of Birth:     /     /     \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Is it ok to leave a message at this number? \_\_\_\_\_

Work: \_\_\_\_\_ Is it ok to leave a message at this number? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

**Have you received counseling, psychological, or psychiatric services in the past? If yes, where and for what reason?**

\_\_\_\_\_  
\_\_\_\_\_

**At times, people have reluctance or hesitation in seeking professional help. Please mark the degree of hesitation/reluctance you feel.**

None    Some    A lot

**Please check the issues, which prompted you to come into counseling today?**

- |   |   |
|---|---|
| <input type="checkbox"/> Relationship/Family problems | <input type="checkbox"/> Thoughts of harming self or other                      |
| <input type="checkbox"/> Health Issues                | <input type="checkbox"/> Alcohol or drug abuse                                  |
| <input type="checkbox"/> Stress                       | <input type="checkbox"/> Questions/concerns about alcohol/drug related problems |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Grief/Death and /or Loss                               |
| <input type="checkbox"/> Crisis                       | <input type="checkbox"/> Traumatic events (emotional, physical, sexual)         |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Anger  |
| <input type="checkbox"/> Eating Problems/Body Image   | <input type="checkbox"/> Work/Academic Problems                                 |

**Other issues you would like to specify:** \_\_\_\_\_

**Please list any prescription drugs currently taken & name of prescribing doctor:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_