



**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Current Health Problems: \_\_\_\_\_

Medications Prescribed: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Emergency Contact:** Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

**Counseling History:** Previous Psychiatric or Psychological Services: \_\_\_ Yes \_\_\_ No

Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for seeking care: \_\_\_\_\_

Treatment outcome: \_\_\_\_\_

Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for seeking care: \_\_\_\_\_

Treatment outcome: \_\_\_\_\_

Please circle any of the following problems that pertain to you:

Nervousness

Shyness

Separation

Drug Use

Anger

Sleep

Relaxation

Legal Matters

Energy

Loneliness

Education

Temper

Children

Bowel Troubles

Depression

Sexual Problems

Divorce

Alcohol Use

Self-Control

Stress

Headaches

Memory

Insomnia

Inferiority Feelings

Career Choices

Nightmares

Appetite

Being a Parent

Fears

Suicidal Thoughts

Finances

Friends

Unhappiness

Work

Tiredness

Ambition

Making Decisions

Insomnia

Health Problems

Marriage

Stomach Trouble

My Thoughts

Additional reasons for seeking care: \_\_\_\_\_

\_\_\_\_\_

List the members of your family and all others in your home:

Name

Age/Birth Date

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_