Enhancing your life with options PLLC

PERSONAL AND FAMILY RECORD **Date**_____

Client Name_____Age_____Birthdate_____
Address_____City_____State_____Zip_____
Phone (Home)_____ (Work)_____ (Cell) _____
Employed by_____How Long_____Position_____
Social Security Number_____ Male___Female___Previous Occupation_____
I may be communicated with electronically? Yes___ No____ It is OK to leave a message? Yes____ No____
Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Marital Status

Single, never married_____ Engaged _____ Living together without marriage _____
Married (year) _____ Separated (year) _____ Divorced (year) _____ Widow/er (year) _____
Total number prior marriages for you_____ For your spouse_____
If married, are you happy in current marriage?_____

Spouse Name_____Age_____Occupation_____
Employer_____How Long_____
Spouse's Social Security Number_____ Date of Birth _____

Children	Birthdate	Sex	Social Security #	Live in your home?

If a Minor

Father_____Address_____
Employer_____Phone (Home) _____(Work)_____
Mother_____Address _____
Employer_____Phone (Home) _____(Work)_____

Insurance Information

Name of Insured _____
Social Security No._____Date of Birth_____Male___Female ___
Employer_____
Insurance Company_____ Policy No._____
Insurance Authorization No._____ Any other Health Insurance? Yes___ No___

Consent for Treatment and Financial Agreement

I, _____, authorize assessment and/or treatment of _____, and I agree to be responsible for all expenses incurred as a result of therapy or assessment at Options of Winston-Salem, PLLC. I agree to pay all charges for me and my immediate family at the time services are rendered. I also authorize release of any information necessary to process insurance claims and authorize payment be made to Options of Winston Salem, PLLC. I understand that I will be charged full fee for appointments missed if not cancelled within 24 hours.

_____Date_____
Client/Custodial Parent/Guardian

Briefly state the nature of the problem as you see it:

_____
_____
_____
_____
_____

What do you want to gain from counseling? _____
_____

MEDICAL INFORMATION

Family Physician_____Phone_____
Psychiatrist/Psychologist_____ Phone_____

Describe your physical health: excellent___ good___ adequate___ poor____ Any allergies? Yes____ No____
Are you taking any prescription drugs? Yes*___ No___ Do you use tobacco? Yes___ No___
*If yes, list the drug names(s), dosage, and purpose: (list on back if additional space needed)

Drug	Dosage	Purpose	Doctor

COUNSELING HISTORY

Have you ever been hospitalized for mental illness or substance abuse? Yes____ No____
If yes, for what reason?_____How long were you in treatment?_____
Hospital name_____Dates of Treatment _____
Did you continue with outpatient counseling? Yes____No____ Name of Counselor _____
Have you ever been to counseling for any reason? Yes_____ No_____
What reason?_____How long?_____Counselor _____
Are you presently working with any other Counselor, Psychologist, or Support Group? Yes ___No____
What reason? _____ How long? _____ Counselor_____

IMPACT OF LIFE CIRCUMSTANCES

Circle any LOSSES that you have experienced:

Death of: Spouse/Partner, Child, Father, Mother, Sister, Brother, Grandmother, Grandfather, Friend
Divorce Separation Broken Engagement Suicide Miscarriage Abortion Infertility Bankruptcy
Homelessness Career or Job Loss Other _____
_____

Circle any VICTIMIZATIONS you have experienced or been involved with:

Child Abuse: Physical Emotional Sexual Incest Spouse Abuse: Physical Emotional Sexual
Abandonment Rape Robbery Assault Suicide Attempt Auto or Industrial Accident Major Illness
Surgery Physical Disability Alienation Other _____
_____

Circle any PROBLEMS that concern you now:

Relationship(s) with: Spouse/Partner Children Parents Siblings In-laws Co-workers Friends Infidelity Teachers Alcohol Street drugs Prescription drugs Binge eating Excessive dieting/exercise Shopping Work too much Procrastination Communication Depression Anger Grief Stress Fear Gender Identity Sex Career Loneliness Mood Swings Self-esteem Codependency Anxiety Feelings about Church or God Other:_____

_____

_____

CURRENT SYMPTOMS

Mood: □Sad □Elated □Hopeless □Low Energy □Poor Concentration □Angry □Appropriate □No Problem □Other_____

Anxiety: □Worry □Panic □Fearfulness □Compulsive □None □Other _____

Thought: □Delusions □Hallucinations □Disorganized Speech □Obsessive □Distractible □No Problem □Other _____

Behavior: □Aggressive □Truant □Runaway □Disorganized behavior □ Compulsive □Hyperactive □Other _____

Sleep Problems, Describe:_____ Appetite Problems, Describe: _____

INTENSE EMOTIONAL DISTRESS

Current Situation: Explanation

Suicidal thoughts, plans, attempts _____
Homicidal thoughts, plans attempts _____
Desire to cause pain to self or others _____
In fear for your life or personal safety _____
Too depressed to care for self or family_____

What is your religious preference? _____
How strong is the influence of your church in your life? _____
Church_____ Pastor _____

Whom should we contact in case of an emergency?

Name_____Relationship_____
Address_____Phone_____

Referral Source:

Name_____Relationship_____
Address_____Phone_____
May we send an acknowledgement? Yes____ No _____