# Application for Services

Please fill out paperwork accordingly and ask if you have any questions.

## Demographics

Client Name:_______________________________________________________ Date: __________________________

Social Security Number:______-______-______ Date of Birth: ____/____/____

Gender: [ ] Male [ ] Female Ethnicity: _____________________________

Home Address:______________________________________________________________________________________
City:______________________________________ State:____________________________________ Zip:___________

Home Phone Number:____________________________ May we leave a message? [ ] Yes [ ] No

Work Phone Number: ____________________________ext.______ May we leave a message? [ ] Yes [ ] No

Mobile Phone Number:___________________________ May we leave a message? [ ] Yes [ ] No

**If the above patient is a minor complete the following:**
Name of Guardian:___________________________________________________________________________________

Address of Guardian:_________________________________________________________________________________

City:______________________________________ State: ________________________________ Zip: ______________

Guardian's Phone:___________________________________________May we leave a message? [ ] Yes [ ] No

## History Information

Who is providing the history information?

[ ] The patient [ ] The patient's guardian [ ] Other__________________________________________________________

Please describe the current complaint or problem as specifically as you can, in your own words.____________________
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

How long have you experienced this problem, or when did you first notice it?_____________________________________
____________________________________________________________________________________________________________

What stressors may have contributed to the current complaint or problem?_______________________________________
____________________________________________________________________________________________________________

## Previous Treatment

Have you engaged in previous counseling? [ ] Yes [ ] No

When and Where? ____________________________________________________________

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.

[ ] Depression/Sad/Down feelings

[ ] High/Low energy level

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Job problems

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Indecisiveness about career

[ ] Hearing voices/Seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Feelings of being cheated

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting

[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating

[ ] Excessive exercise

## **Medical History**

List any current or important past medications

______________________________________________________________________________________

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

______________________________________________________________________________________

How would you rate your current physical health? [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Do you have a primary care physician? [ ] Yes [ ] No
If yes, complete the following:

Name:_______________________________Address:___________________________________________

Phone Number:________________________

## Family History

Relationship with parent figures: (good, fair, poor, close, distant, etc.)

Mother:_______________________________________________ Age:______

Father:_______________________________________________ Age:______

Step-parent:___________________________________________ Age:_____

Other:________________________________________________ Age:_____

List your siblings and describe your relationship with them? (Name, Age, Relationship)
1)____________________________________________________________________________________________
2)____________________________________________________________________________________________
3)____________________________________________________________________________________________
4)____________________________________________________________________________________________

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?_____________________________
_______________________________________________________________________________________________

Any family history of substance abuse, mental illness, suicide, or violence?_____________________________________
_______________________________________________________________________________________________

## Social History

Describe your relationship with peers, friends, social support network?_________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Describe your hobbies/interests:_________________________________________________________________________
________________________________________________________________________________________________

Describe any cultural concerns:__________________________________________________________________________

## Educational History

When attending school where you:
[ ] In regular classes [ ] Home Schooled [ ] Special education [ ] Advanced classes [ ] Ever suspended [ ] Alternative

What is the highest educational level you have completed?__________________________________________________

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)_________
_______________________________________________________________________________________________

## Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed [ ] Self-employed [ ] Student [ ] Other

Employer: _________________________________________ Length of Employment: _________________________
Are you satisfied with your employment?________________________________________________________________
If not, why?__________________________________________________________________________________________

## Marital History

Which best describes your marital status?

[ ] Married, Date: _________ [ ] Never Married [ ] Widowed, Date: _________
[ ] Separated, Date: _________ [ ] Divorced, Date:_________

If you are married, which best describes your marital satisfaction?____________________________________________
________________________________________________________________________________________________
Rate your marriage satisfaction currently: [ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

Name of Spouse/Parnter:__________________________________________________________________________
Nature of Relationship: __________________________________________________________________________

Do you have children? [ ] Yes [ ] No

If yes, complete the following: (Biological/Step/Adopted)
1) Name____________________________________Age_____Gender__________Relationship:__________________
2) Name____________________________________Age_____Gender__________Relationship:__________________
3) Name____________________________________Age_____Gender__________Relationship:__________________
4) Name____________________________________Age_____Gender__________Relationship:__________________
5) Name____________________________________Age_____Gender__________Relationship:__________________
6) Name____________________________________Age_____Gender__________Relationship:__________________

Ex-Spouse/Partner:
Name:______________________________________Age_____ Children? [ ] Yes [ ] No
Name:______________________________________Age_____ Children? [ ] Yes [ ] No

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No

If yes please complete the following:

Case Worker's Name:________________________________________Phone:________________________________

## Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Are you on probation or parole? [ ] Yes [ ] No

Name of Probation Officer and County: ________________________________________________________________

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No: If yes, complete chart below:

List any Arrests/Convictions (including approx. dates) :_____________________________________________________
________________________________________________________________________________________________

Additional Information_____________________________________________________________________________

## **Substance Abuse History**

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, etc)
[ ] Yes [ ] No

| Substance | Current/Past | Route | Amount/Frequency/Duration | Last Use | Onset |
|---|---|---|---|---|---|
| Tobacco | | | | | |
| Alcohol | | | | | |
| Marijuana | | | | | |
| Cocaine/Crack | | | | | |
| Pain Meds | | | | | |
| Heroin | | | | | |
| Hallucinogens | | | | | |
| Benzos | | | | | |
| Amphetamines | | | | | |
| Club/Designer | | | | | |
| Other: | | | | | |

Name of Treatment Facility: ______________________________Dates attended: _______________________________

Name of Treatment Facility: ______________________________Dates attended: _______________________________

Type of Treatment (circle all that apply): Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

## **Referral Source:**

Who referred you to our office, or how did your learn about our practice?_______________________________________

_____________________________________________ _________________________

*Signature of client* *Date*

_____________________________________________ _________________________

*Signature of Guardian, if required* *Date*