

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can.

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Present Address \_\_\_\_\_  
*Number Street*  
 \_\_\_\_\_  
*City County State Zip Code*

Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Presently living with: Parents \_\_\_\_\_ Spouse \_\_\_\_\_ Roommate \_\_\_\_\_ Alone- Other \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ (# of Years \_\_\_\_\_) Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Occupation \_\_\_\_\_ Total hours/week \_\_\_\_\_

Employed by \_\_\_\_\_ Phone \_\_\_\_\_

Years of Education \_\_\_\_\_ Religious Affiliation \_\_\_\_\_

Church \_\_\_\_\_ Active \_\_\_\_ Inactive \_\_\_\_

Family member to notify in case of emergency: Name: \_\_\_\_\_

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

Referred by \_\_\_\_\_

FAMILY MEMBERS				
Relationship	Name	Age	Grade in School last Completed	Occupation if Out of School
Spouse	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Describe any physical problems you have that require medication or physical care: \_\_\_\_\_

\_\_\_\_\_

Are you currently receiving medical treatment? Yes \_\_\_ No \_\_\_

Are you currently taking any prescription drugs? Yes \_\_\_ No \_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Previous Counseling / Therapy Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

Where and with whom? Name: \_\_\_\_\_

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

In your own words, briefly describe the main problem that prompted you to seek counseling at this time:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been times when the problem got better or disappeared? Yes \_\_\_ No \_\_\_

If so, when? \_\_\_\_\_

What do you think helped? \_\_\_\_\_

\_\_\_\_\_

Were there times when the problem was especially bad? Yes \_\_\_ No \_\_\_

If so, when? \_\_\_\_\_

What made it bad? \_\_\_\_\_

\_\_\_\_\_

Are there other people who play a major role in:

1. Causing your problems? (Yes \_\_\_ No \_\_\_ ) 2. Helping you to cope with your problems? (Yes \_\_\_ No \_\_\_ )

Explain briefly: \_\_\_\_\_

\_\_\_\_\_

Do you have any history of abuse (physical, sexual, emotional or spiritual)?

\_\_\_\_\_

Is there anything else that you believe might be important for your counselor to know at this time?

\_\_\_\_\_

Problem Area: In the following list, place a check mark next to each item that identifies an area of concern to you. Place two checks by those items that are most important. (You may add comments after areas checked).

- |   |  |
|---|--|
| <input type="checkbox"/> Anger                              | <input type="checkbox"/> Religious/Spiritual Concern     |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Sexual concerns                 |
| <input type="checkbox"/> Education                          | <input type="checkbox"/> Thoughts of suicide             |
| <input type="checkbox"/> Eating difficulties                | <input type="checkbox"/> Trouble making decisions        |
| <input type="checkbox"/> Fearfulness                        | <input type="checkbox"/> Unhappy most of the time        |
| <input type="checkbox"/> Financial problems                 | <input type="checkbox"/> Use of alcohol                  |
| <input type="checkbox"/> Marital problems                   | <input type="checkbox"/> Use of alcohol by family member |
| <input type="checkbox"/> Physical problems                  | <input type="checkbox"/> Use of drugs                    |
| <input type="checkbox"/> Problems with social relationships | <input type="checkbox"/> Work                            |
| <input type="checkbox"/> Problems with children             | <input type="checkbox"/> Worry                           |
| <input type="checkbox"/> Problems with parents              | <input type="checkbox"/> Other (specify) _____           |

I have read the ALC Information Sheet and voluntarily request counseling services in accord with terms described on the information sheet.

Signature \_\_\_\_\_

Date \_\_\_\_\_

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Guardian \_\_\_\_\_

Date \_\_\_\_\_

**PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION**