Ann Anderson Counseling & Consulting

PLEASE FILL OUT ALL AREAS OF THIS FORM

Name ________________________________Todays date:________________

Date of Birth __________

Address ____

Telephone (home) _________________ (work) _____________________
(cell) ___________________

May I call you at your home number? Yes No
May I call you at your work number ? Yes No
May I call you at your cell number? Yes No

Email____

Referred by: ____

Current Insurance____

Emergency Contact:_______________________________________PHONE#
Are you in need of any special services(wheel chair, interpreter)?_________________

Please state your reason(s) for seeking counseling at this time: _______________________

____

____

Occupation:____ Number of years in this type of work:__________
Retired: Number of years in retirement:___________ Occupation when in workforce *(please fill out the previous line)*
Primary care physician: Name:____
Phone:______________________
Insurance coverage ____
How did you hear about us? *Please circle one and write the name*
Current patient:____________________________________
Friend:____
Doctor:____
Insurance:____
Other:____

Volunteer Work____

Hobbies/interests____

Last School Attended____

Please indicate if any of the following pertain to you: (indicating "yes" does not make you ineligible for treatment, however, it may restrict some of your treatment modalities). Please feel free to expand on any health conditions of concern.

____hepatitis ____HIV ____high blood pressure ____seizures ____pacemaker ____blood-thinning meds
___pregnancy ____Surgically implanted joint/bone replacement or stabilizers?

Nutrition

Do you drink coffee?___________ If yes, how much per day?____

Do you drink caffeinated tea?___________ If yes, how much per day?____

Do you drink soda pop? regular diet none *(Please circle one)* If yes, for how long?_____________________

Do you have regular eating habits? Yes No

Do you eat while engaged in other occupations? Yes No

Do you eat more when under stress or feeling depressed? Yes No

Do you experience sudden drops in energy? Yes No If yes, when?_______________________________________

Please describe a typical day's diet for you: Breakfast	Lunch	Dinner	Snacks(what hour?)

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Do you consider yourself to be spiritual or religious? ☐No ☐ Yes
If yes, describe your faith or belief:

____

____

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist, etc.)? Yes No
If yes, please provide the name and title of the practitioner(s), the condition being treated and the length of time you have been receiving this treatment:
Practitioner Condition Length of treatment to present

____

____

____

Please list all past medical conditions for which you were hospitalized and/or received surgery (include the dates).

____

____

____

Current Health Concerns

Please list your health concerns in order of priority:

1. ____

2. ____

Habits and Lifestyle

Do you smoke?______ If yes, what?______________ How much per day?________________ Since when?_________
Do you drink alcohol?______ If yes, what?_______________ How much?_________________ How often?_________
Do you exercise regularly?______ If yes, please describe what you do:____
Emotional stress scale *Please circle*
1 2 3 4 5 6 7 8 9 10
No Stress Moderate Extremely stressed
What do you do when you want to release stress and/or just relax?____
How many hours do you usually sleep per night?____________________ When do you go to bed?_________________
Do you wake feeling refreshed?____
What is your height?________ What is your present weight?________ What was your weight one year ago?________
What is the most you have ever weighed?______________ When?______________________________

How would you describe your alcohol use?

never light moderate heavy

How would you describe your drug use?
never light moderate heavy

If you use Marijuana how often and times of the day___________________________________

Additional concerns: related to alcohol or drug use:

____

PHYSICAL HEALTH

How would you describe your overall physical health?
_____very good _____good _____fair _____poor

Date of last medical check-up: ______ Physician: _____________________________

Did you have a blood test? Y N If so were there any significant results (high cholesterol etc.)?____

Please list medications you are currently taking, including over-the-counter medications, and the dosage of each:

Date of last medical check-up: ______ ____________________________
(Physician)

Medications:

Name mg purpose of medications

____

____

____

____

____

____

____

____

____

____

If you were referred by another professional (counselor, doctor, lawyer, minister), may I acknowledge the referral?
(Please circle) Yes No NAME:___________________________

Have you had previous counseling and/or psychiatric care? Yes No

If so, when and with whom? ____

What was helpful or not helpful?____

RELATIONSHIP HISTORY

Are you a caregiver for dependents? Yes No If yes, how many children?______ How many adults______

Relationship status:
single married partnered separated divorced widowed

If you are in a relationship now:
Name of spouse/partner ___________________________ Age _______
Past marriages: ____

How long have you been together? ______________________________
Occupation of spouse/partner: _________________________________
What are three words that first come to mind to describe this relationship?
____

Names and birthdates of any children (living or deceased)
____

____

FAMILY OF ORIGIN
Mother's name __________________ Father's name ________________
If still living, where do they live? If deceased, please give date and cause of death. Mother __________________Father__________________
Please list stepparents, past and present ___________________________
____

Please list your brothers and sisters and their age where they live:
____
____

Please identify your strengths:

Identify any challenges you believe you face to accomplish your goals in therapy:

Additional Information you feel might be important that has not been previously asked:

Client Signature ____date_____

Therapist Signature____date______
Ann Anderson , LCSW, LISW, LADAC, LADAC. LPCC