INFORMATION REGARDING ADULT CLIENT OR PARENTS OF A CHILD CLIENT

To be completed by every person seen who is age 17 or older, whether or not the individual is the identified patient; Is to be completed by parent/custody-holder of any child or teenager who is seen, about self (not about child).

In order for your therapist to be most helpful, it is necessary that you supply him/her with a substantial amount of personal information. Please provide as much of the following information about yourself and your family as you are comfortable with sharing. This information is strictly confidential.

Full, Legal Name_____Date of Birth_____

Complete Address _____Current Age_____

City/State/Zip_____Check: Male_____ Female_____

Home Phone _____Cell Ph_____

Work Phone _____Spouse/Partner's Work Phone _____

Please circle Marital Status: Never Married Married Separated Divorced Widowed Living with someone

If Married, Spouse's Name: _____ Date Married: _____

Number Times You Have Been Married: _____ Number Times Your Spouse/Partner Has Been Married: _____

Please list all of the persons who live with you, their relationship to you, and their approximate ages _____

_____

_____

Who Can Be Contacted in Case of Emergency _____ Relationship to You _____

His/Her Phone(s) _____City/State _____

Your Occupation _____Employer: _____

Usual Work Hours: _____Approximate Annual Yearly Income: _____

Length of Time at This Job: _____ Circle Level of Job Satisfaction: Excellent Good Okay Fair Poor

Spouse's Occupation _____Employer: _____

Usual Work Hours: _____ Approximate Annual Yearly Income: _____

Length of Time at This Job: _____ Circle Level of Job Satisfaction: Excellent Good Okay Fair Poor

Circle all that Apply: Retired Unemployed On medical, family, or other leave from work Seeking employment

Are you (or minor child) on Disability? _____ Seeking Disability? _____ Planning to seek Disability? _____

Level of Education Completed (Circle): Grade 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Graduate Level
Level of Education Spouse Completed: Grade 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Graduate Level

List your children and their ages if different from the persons listed above who live with you _____

_____

Over, Please!

Nationality or cultural group? _____ Who referred you to Cross Keys? _____

Circle your therapy preference: Individual Couple Entire Family Parent(s) & Child/Teen Group Mixture Unsure

Approximately how many sessions do you think may be needed? _____

Please give a brief explanation of your problem situation: _____

_____

Are you or a family member experiencing suicidal feelings? _____If so, who? Please explain the frequency and severity of these feelings: _____

Have you or any member of your family ever attempted or completed suicide? _____

List any medications taken, the dosage, when taken, what each one is for, and the name of the prescribing physician. It is often important that your therapist know *what medications are in your household. Use an extra sheet of paper, if needed.*

Self _____

Spouse _____

Child/Teenager _____

Have you sought counseling before? _____ If so, approximately when, whom did you see, and for about how many sessions? Was it helpful?_____

_____

Have you or has any member of your family been hospitalized for emotional reasons? Please explain:_____

_____

Is there any physical violence or other abuse in your home, or do you fear that violence may occur? Please explain. _____

_____

Do you prefer Christian counseling? _____ Do you feel a need for help with spiritual matters?_____

Which of the following best describes your religion? (Circle) Atheistic Agnostic Christian Muslim Jewish Other

Church member? Where? Circle: _____ Active or Inactive? Leader?

Which best describes your spouse's/mate's religion? (Circle) Atheistic Agnostic Christian Muslim Jewish Other

Church member? Where? Circle: _____ Active or Inactive? Leader?

Who is the primary client's family physician? _____ Approximate date last seen: _____

Have you seen any mental health specialist within the last year? _____If so, whom? _____

IF YOU ARE A PARENT BRINGING YOUR MINOR CHILD (UNDER AGE 18) FOR COUNSELING, PLEASE ALSO COMPLETE THE "INFORMATION REGARDING YOUR CHILD" FORM. THANK YOU.

_____ _____

Date Name of person completing form