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Biographical Information

Name: _____ Phone #: _____

Occupation: _____ How Long? _____

Physician: _____ Date of Last Visit: _____

Relevant medical conditions (History, current conditions, changes in condition):
_____
_____

Please list Medications & Prescribing Doctor:
_____
_____

Married Single Widowed Partner Name: _____ Relationship: _____

Children (Names & Ages): _____

History of Counseling, Psychiatric Hospitalizations, Alcohol and or Drug problems:
_____
_____

What brings you to counseling?

Why have you decided to come for counseling at this time? What has happened that makes you come now?

What would you like to change about yourself to make your situation better?

These symptoms may or may not be related to the problem which brings you to treatment. However, they help us plan your treatment.

__Trouble going to sleep
__Restless sleep
__Waking up early & being unable to fall back to sleep
__Sleeping too much
__Feeling guilty
__Depressive feelings generally worse in morning
__Thoughts of suicide
__Made suicide attempts
__Fatigue or loss of energy
__Poor concentration & memory
__Decreased sex drive
__Feelings of restlessness
__Loss of pleasure in usual activities
__Loss of appetite
__Feelings of worthlessness
__Weight loss/Gain
__Feelings of sadness or depression
__Uncontrollable habits
__Arguing with others
__Feeling people dislike you
__Wanting to be left alone
__Feeling bored by others
__Feeling alone even with others
__Relationship problems
__Afraid of losing control
__Light headedness, Shortness of breath, trembling
__Vomiting
__hot or cold spells
__Numbness or tingling in parts of your body
__Allergy problems
__High blood pressure
__Menstrual irregularity or distress
__Asthma attacks
__Hives
__Irritable bowels, constipation
__Tics
__Smoking
__Overconsumption of sugar or sugar cravings
__Eating disturbance
__ Frequent colds or flu
__Minor accidents
__Grinding teeth/jaw tension
__Withdrawing from others
__Feeling critical of others
__Feeling shy or uneasy
__Difficulty communicating what you really feel or think
__Feeling inadequate or less than others
__Other do not understand you
__Others do not understand you
__Others not meeting your needs
__ Avoid certain situations
__Palpitations, sweating, chest pains, cold clammy hands

Name (Print): _____

Signature: _____ Date: _____