FAMILY COUNSELING SERVICE

CLIENT INFORMATION

Client's Last Name _____ First _____ SS#_____

DOB _____ Age _____ Race _____Gender _____ Religion_____

Phone: Home_____ Work_____ Cell_____

Name of Legal Guardian(s) (if under age 19): _____

Would you like to have access to our online patient portal? ☐ Yes ☐ No Email_____

Address _____ City, State, Zip _____County_____

Spouse's Last Name _____ First _____ Date of Marriage _____

DOB_____ Age _____ Race _____ Gender _____ Religion _____

E-mail_____ Phone: (Spouse) Home _____ Cell _____

Education: Self_____ Spouse Education _____

Employer: Self_____ Spouse Employer _____

Physician: Self _____ Spouse _____ Children _____

Children: Name _____ Age _____; Name _____ Age _____

Name _____ Age _____; Name _____ Age _____

How did you hear about us? ☐ Website/Internet ☐ Brochure ☐ Friend ☐ Insurance Company ☐ Doctor

☐ Pastor ☐ Attorney ☐ Another Counselor ☐ EAP ☐ School ☐ Court

Session cost will be covered by? ☐ **EAP** ☐ **Insurance** ☐ **Self Pay** ☐ **Positive Directions** ☐ **Other**

If cost is covered by an EAP, please list employer: _____ If other, please identify: _____

INSURANCE INFORMATION

Person Responsible for Bill: _____ Date of Birth: _____

Method of Payment: ☐ Insurance ☐ Credit Card ☐ Cash or Check ☐ Co – Pay $_____ due today

Is this patient covered by insurance? ☐ Yes ☐ No Insured's Date of Birth: _____

Insurance Name: _____Contract #: _____

Policy Holder: _____Group #: _____

Secondary Insurance: _____Contract #: _____

Policy Holder:_____Group #: _____

Client's relationship to Insured: ■ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder Address: _____Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Family Counseling Service or insurance company to release any information required to process my claims.

_____

Client Signature **Date**

Office Use Only: **Fee Per Session: _____**

Case #: _____ Counselor: _____Date: _____

Family Counseling Service
Client Questionnaire

Client Name: _____ Date: _____

Over the past 6 months, how often have you been bothered by any of the following problems?	Not at all	1-2 Times	Several Days	More than half the days	Nearly everyday
Depressed mood (feeling sad, empty)					
Feelings of hopelessness					
Diminished interest or pleasure in activities					
Weight loss of over 5% in the past month when not dieting					
Decrease or increase in appetite					
Problems getting enough sleep or sleeping too much					
Moving or speaking so slowly that other people have noticed					
Fidgety or restless/moving around more than usual					
Fatigue or loss of energy					
Diminished ability to think, concentrate or make decisions					
Recurrent thoughts of death					
Feelings of low self-worth					
Anxiety in social settings					
Feeling anxious overall					
Feelings of losing control					
Excessive worry					
Feeling restless, or on edge					
Irritability					
Tension					
Feelings of panic					
Socially withdrawn					
Making careless mistakes					
Do not complete tasks					
Difficulty staying organized or focused					
Forgetful					
Confused					
Disoriented					

Family Counseling Service
Client Questionnaire

Over the past 6 months, how often have you been bothered by any of the following problems?	Not at all	1-2 Times	Several Days	More than half the days	Nearly everyday
Compulsive checking or counting					
Indecisiveness					
Feeling emotionally distant from others					
Racing thoughts					
Impulsiveness					
Recurrent or distressing dreams					
Sexual problems					
Gender concerns					
I don't like my body					
Intense fear of weight gain					
I do risky or dangerous things					
Binge eating					
Laxative abuse					
People talk about me					
Some people want to hurt me					
I hear voices or sounds others do not hear					
I see things others do not see					
I smell things others do not smell					
My symptoms significantly impact my social, work, or family life.					
Sometimes I think I would be better off dead					
I think of hurting myself in some way					
I have engaged in self-mutilation					
I have tried to hurt myself					
Thoughts of hurting someone else					

Have you ever been exposed to a significant traumatic event, such as a violent event, serious accident, life-endangering event or other life-changing incident? ☐ YES ☐ NO

In your own words, please describe what has led you to seek counseling?

_____

_____

_____

Family Counseling Service
Client Questionnaire

Personal Medical History:

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Asthma/respiratory problems
- ☐ Stomach or intestinal problems
- ☐ Cancer (type)
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Epilepsy or seizures
- ☐ Chronic pain
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Head trauma
- ☐ Liver problems
- ☐ Other

Do you have any other current medical problems? _____

_____

_____

Do you have any past medical problems, hospitalization, or surgeries? _____

_____

_____

Current Weight: _____ Height: _____

Current Psychiatric Medications:

Please list any psychiatric medications you are taking, even if prescribed by your family physician.

Medication Name	Total Daily Dosage	Estimated Start Date

List any other current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Family Counseling Service
Client Questionnaire

How many caffeinated beverages do you drink a day? Coffee_____ Sodas_____ Tea_____

Do you smoke cigarettes or used tobacco products (chewing tobacco, pipes, cigars) ☐ Yes ☐ No

If yes, what type _____ and how often _____

Past Psychiatric History:

Outpatient treatment? ☐ **Yes** ☐ **No** If yes, please describe when, by whom, and nature of treatment.

Reason Dates Treated By whom

_____

_____

Psychiatric Hospitalization? ☐ **Yes** ☐ **No** If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol Abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No	Violence	☐ Yes	☐ No

If yes, who had each problem? _____

_____

_____

Emergency Contact:

Name: _____ Relationship: _____

Telephone #:_____