HopeLife Counseling

Healey E. Ikerd, MS, LPC, LMFT, CCMHC
PO Box 11051; Fayetteville, AR 72703
479-202-4206

This information is kept confidential.

Date: _____

Name: _____

Gender (M/F)_____ Age: _____ Date of Birth: _____

Street Address: _____

City:_____State:_____Zip: _____

Home Phone:_____ Cell Phone: _____

Is it okay to leave a message at either of these numbers? _____

Employed by: _____ Work Phone: _____

Email: _____/_____

Is it okay to email you? _____

Religious Preference: _____

Please rank the importance of your faith and spiritual issues:
(lowest) 1 2 3 4 5 6 7 8 9 10 (highest)
Do you want your faith integrated into counseling? _____

Family Information

Marital Status: Single _____Separated _____ Married_____Divorced____ Widowed ____

If Single, Dating _____ Committed relationship _____ Engaged _____

If married, number of years: _____ If divorced, number of years: _____

Spouse Name: _____ Age: _____

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Children: (Name and Age)

_____

_____

_____

Medical Information

General Health_____

Are you now under a doctor's care?_____If yes, name of doctor_____

Reason for doctor's care_____

Are you taking any medication?_____If yes, what kind?_____

Reason for medication_____

Do you use alcohol or drugs to (check all that apply): Manage stress?_____ To relax?_____ To change mood?_____ For sleep?_____ If yes, how many years? _____

Crisis Information

Are you having any current suicidal thoughts, feelings or actions?
Y___ N___ If yes, please explain: _____

Any current homicidal or violent thoughts or feelings, or anger control problems?
Y___ N___ If yes, please explain: _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior?
Y___ N___ If yes, please explain: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?
Y___ N___ If yes, please explain: _____

In case of emergency, who is to be contacted?

Name: _____ Relationship: _____

Phone (s): _____

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Primary reason for seeking services:

____ Anger Management	**____ Anxiety**	**____Coping Skills**	**____Depression**
____ Eating Disorder	**____ Fear/Phobias**	**____ Trauma**	**____ Sexual Concerns**
____ Sleeping Problems	**____ Addiction**	**____ Grief**	**____ Spiritual Issues**
____ Relationship Concerns	**____ Marital Issues**	**____ Career/Job Issues**	**____ Infidelity**
____ Sexual Abuse	**____ Domestic Abuse**	**____ Court Ordered**	**____ Parenting**

Other Mental Health Concerns: _____

Previous counseling experience: _____

_____

What do you hope to gain from therapy*?* _____

_____

_____

Other information (past or present) that might be helpful for therapist to know: _____

_____

_____

Referred by: _____
No information is shared with referral source.

Signature: _____ Date: _____