Patient's Name: **Date of Birth:** **Sex:**
Patient's Address:

Patient's Telephone: **Patient's Email:**

Patient's Emergency Contact Name, Telephone, and Relationship:

Name of Insurance: **Insurance ID:** **Insurance Group No.:**

EAP Prior Authorization No: **Number of EAP Visits**

Insured's Name: **Insured's Date of Birth:**

Insured's Address:

Patient's Legal Guardian/Parents' Name(s), Address, and Telephone:

Patient's Marital and Family Information:

Patient's Marital Status:

Patient's Children Information:

Patient's Occupational and Educational Information:

Patient's Current Work and/or School:

Patient's Current Work Position and/or Grade Level:

Patient's Highest Level of Education Achieved:

Patient's Current Medical Conditions:

MEDICATION/PURPOSE	DOSAGE	START DATE	PRESCRIBED BY

Patient's Primary Care Physician Name, Telephone, and Address:

Drug and Alcohol History: Mark Those Applicable and Date Last Used and If Treated		
Substance	**Date Last Used**	**Current or Past Treatment**
Tobacco		
Alcohol		
Marijuana		
Opiates/Heroin		
Methamphetamine/Stimulants		
Cocaine		
LSD		
Mushrooms		
Pain Killers		
Inhalants		
Other		

Reason for Seeking Evaluation Today:

What goals do you have for us to accomplish in our time together?

On a scale of 1 to 10, rate the severity of your situation at this time:

1*******2*******3******4*******5*******6*******7*******8*******9******10

Mild Moderate Very Severe Extremely Severe

AREAS OF CONCERN	CHECK ALL THAT APPLY TO YOU
DEPRESSION	
ANXIETY	
LOW SELF-ESTEEM	
ANGER MANAGEMENT ISSUES	
POOR CONCENTRATION	
HOPELESSNESS	
SADNESSS	
GUILT	
THOUGHTS OF HURTING SELF	
PHOBIAS	
OBESSIVE THOUGHTS/COMPULSIVE	
SLEEP DISTURBANCE	
CHRONIC PHYSICAL PAIN	
ISSUES AROUND EATING AND FOOD	
BODY IMAGE ISSUES	
MARITAL ISSUES	
RELATIONSHIP ISSUES	
WORK ISSUES	
CHILD REARING ISSUES	
SEXUAL ABUSE ISSUES	
HYPERACTIVE	
SPOUSAL ABUSE ISSUES	
ALCOHOL / SUBSTANCE ABUSE	
STRESS	
LEARNING PROBLEMS	
PHYSICAL ABUSE ISSUES	
VERBAL ABUSE ISSUES	
DELUSIONS/HALLUCINATIONS	
CONFUSION	
DEFIES RULES/AUTHORITY	
SOCIAL WITHDRAWAL	
ABUSE OF PRESCRIPTION DRUGS	
FEARS OF DYING	

Do you have any previous counseling experiences? YES or NO

If yes, what was helpful? _____

Please tell me anything else that would assist me in helping you._____