Confidential Single Parent

GENERAL INFORMATION

Date: ______________________ Purpose/Goal For This Visit?______________________Referred by: ________________

Full name: ____ Name you prefer: _________________________

Best Number to Call ____

Email Address: ____

What is your goal for today? ____

What other Agencies have you applied to?____

____

What would you like to see accomplished in the next 30 days? ____

What Steps have you taken this week towards your goal? ____

Who is holding you accountable towards your goals? (Name) ____

Phone Number: Cell: ____ Office: _________________________________

What Dream do you have for yourself? ____

Sex: ❑ Male ❑ Female Date of birth:__________________________ Age:_____________________________________

Ethnicity: ❑ White ❑ Black ❑ Hispanic ❑ Asian ❑ Other: ____

Street address: ____ Suite/Apartment #: ___________

City: ____ State: ________________ Zip code: _________________

May we send mail here: ❑ Yes ❑ No

Mailing address or Post Office Box: ❑ Same as above

Street address: ____ Suite/Apartment #: _____________

City: ____ State: ______________ Zip code: _____________________

May we send mail here: ❑ Yes ❑ No

Home Phone: ____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone: ____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone: ____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Email: ____ Contact you here? ❑ Yes ❑ No

Employer: ____ How long have you been there: ________________

Occupation: ____ Average hours worked per week: _______________

Highest level of education completed: _________________________ Are you currently in school? ❑ Yes ❑ No

If Yes, what level? _____________________________ Degree pursuing: ____

SPIRITUAL BACKGROUND

Do you regularly attend a place of worship: ❑ Yes ❑ No If yes, where? ____

What is the name of your pastor, priest, rabbi, or other spiritual leader? ____

What words would you use to describe yourself? ____

If God were to describe you, what would He say? ____

Briefly describe the religious environment of your home as you were growing up: ____________________________________

____

Complete the following thought: God is____

Do you have a personal support system: ❑ Yes ❑ No If yes, where? ____

RELATIONAL INFORMATION

Current marital status: ❑ Single Mom ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long?__________________________________

Number of previous marriages for you? ___________________ For your partner/spouse? ___________________

Partner's/Spouse's name:____ Partner's/Spouse's age:___________

Is your partner/spouse supportive of you seeking to volunteer? ❑ Yes ❑ No ❑ Unsure ❑ He/She doesn't know

With whom do you currently live? (*Check all that apply*) ❑Alone ❑Spouse ❑Children ❑Parent(s) ❑Sibling(s)
❑Boyfriend ❑Girlfriend ❑Roommate ❑Other:_____________________________________

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? ___________________________________

Have you ever had a miscarriage or medical abortion? ❑ Yes ❑ No. If Yes, when? __________________________

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs *(Use the back of page, if necessary)*:

Therapist's Name or Program	Major Issue	Approximate Dates

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries *(Use back of page if necessary)*:

____

Your height: ____________________ Your weight: ____________________

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _________lbs. ❑ down __________ lbs.

List all current medications you are taking, including those you seldom use or take only as needed*(Use back of page if necessary)*:

Name of medication	Dose	Reason for taking medication

Have you ever had or have you now any of the following *(Check boxes & if yes, indicate year of first occurrence)* :

Issue	Yes	No	Year	Issue	Yes	No	Year
High blood pressure				Dizziness/fainting			
Heart problems				Head injury			
Respiratory problems				Ulcers			
Asthma				Intestinal problems			
Cancer				Hepatitis			
Thyroid problems				Abdominal problems			
Diabetes				Anemia/sickle cell			
Frequent or severe headaches				Sinus problems			
Anorexia/Bulimia				Arthritis			
Other eating disorders				Smoke cigarettes			
Sexually transmitted disease(s)				Seizure disorder			

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No

Have you experienced them in the past? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

If Yes, when and how: ____

Have any of your friends or family ever committed or attempted suicide? ❑ Yes ❑ No

If Yes, when and who: ____

Are you presently experiencing any thoughts of harming another person? ❑Yes ❑No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past	Present	Past	Present	Past
❑	❑ Stress	❑	❑ Fears	❑	❑ Controlled by others
❑	❑ Anxiety or worry	❑	❑ Shyness	❑	❑ Obsessive thoughts
❑	❑ Panic	❑	❑ Low self-esteem	❑	❑ Compulsive behaviors
❑	❑ Depression	❑	❑ Don’t like myself	❑	❑ Seeing things others don’t see
❑	❑ Crying all the time	❑	❑ Marital problems		
❑	❑ Lack of motivation	❑	❑ Other relational problems	❑	❑ Hearing voices
❑	❑ Fatigue/Lack of energy	❑	❑ Parenting problems	❑	❑ Racing thoughts
❑	❑ Poor appetite or overeating	❑	❑ Physical abuse	❑	❑ Eating problems
❑	❑ Trouble sleeping	❑	❑ Emotional abuse	❑	❑ Drug use
❑	❑ Poor concentration	❑	❑ Verbal abuse	❑	❑ Alcohol use
❑	❑ Feeling worthless or inferior	❑	❑ Sexual abuse	❑	❑ Pregnancy
❑	❑ Feeling hopeless	❑	❑ Sexual problems	❑	❑ Abortion
❑	❑ Guilt	❑	❑ Gender identity	❑	❑ Legal matters
❑	❑ Death of friend or loved one	❑	❑ Anger	❑	❑ Work stress
❑	❑ Grief	❑	❑ Aggressive behavior	❑	❑ Career choices
❑	❑ Chronic pain	❑	❑ Bad dreams	❑	❑ Indecisiveness
❑	❑ Physical disability	❑	❑ Unwanted memories	❑	❑ Lack of discipline
❑	❑ Terminal illness	❑	❑ Loss of control	❑	❑ Financial problems
❑	❑ Health concerns	❑	❑ Impulsive behavior	❑	❑ Spiritual apathy
❑	❑ Loneliness	❑	❑ Controlling	❑	❑ Other______________

Please use an “X” on the scale below to indicate how distressing your problem(s) are to you.

Minimally Distressing	Moderately Distressing	Extremely Distressing

Please describe why you are coming to counseling *(i.e., What are your issues, problems?)*: ____________________

____

Why have you decided to come for counseling now? ____

____

What do you hope to gain or change by coming for counseling? ____

____

IN CASE OF EMERGENCY, CONTACT:

Name:______________________________ ___________________ Relationship: _________________________

Home phone: ___________________________________ Cell phone: ____________________________________

STATEMENT OF TRUTH & AGREEMENT

I understand that I grant permission to our organization to verify this information with the appropriate parties involved. I also acknowledge and affirm that all the information on this form is true to the best of my ability.

Signed: ____ Date: ____________________