Seed of Hope Counseling
Hope. Connect. Grow.
108 E. Main Street, Suite 210B Kingsport, TN 37660
423-530-7042

Today's Date: _____ /_____ /_____

Client Full Name: _____

Address: _____ City/State/Zip/County: _____

Client's Date of Birth: _____/_____/_____ Social Security Number: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( ) _____ Email:_____

Which number(s) may we use to contact you? Please circle: Home / Cell / Work

At which number(s) may we leave a message? Please circle: Home / Cell / Work / None

May we contact you via: Mail? YES / NO Text Message? YES / NO Email? YES / NO

If yes to text or email: I understand that text/email transmissions may not be secure and will not be used for the purpose of communicating my personal health information. Client signature: _____

Occupation: _____ Place of Employment: _____

Gender: M / F Ethnicity: _____ Marital Status: Single / Married / Divorced / Widowed / Separated

Spouse/Parent/Guardian:	**Emergency Contact Person:**	**Name of Physician:**
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Office Location: _____
_____	_____	_____
Date of Birth: ____/_____/_____	Phone: ( )_____	Phone: ( ) _____
Phone: ( ) _____		Last Physical Exam:____/____/_____

Person Financially Responsible: _____

Phone #: _____ Address: _____

Do you have medical/health insurance? YES / NO If so, what insurance company? _____

Known Allergies: _____

Medical Problems/Other Diagnoses: _____

_____

Current Medications & Dosage (including supplements): _____

_____

_____

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed? If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately. _____

_____

Do you have any current or prior legal issues? YES / NO
Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them. _____

_____

Religious/Faith Affiliation: _____
Do you consider your faith/religion meaningful in your life? YES / NO

What significant educational and work/volunteer experiences have you had?
_____

_____

What is the highest level of education you have completed? Are you currently employed? If so, where and for how long?
_____

_____

Briefly describe the reason(s) you are seeking counseling: _____
_____

_____

Please give more details about the issue you named above:
When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?
_____

_____

Have you ever experienced similar or other mental health symptoms before?
If so, what was your experience like? When did it happen?
_____

_____

Previous Mental Health Services:

Type of Service	Provider	Date(s) of Service

Are you currently seeing a psychiatrist or another therapist? YES / NO
Name of Psychiatrist / Therapist: _____

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Have you ever received counseling at Seed of Hope Counseling? YES / NO
Name of therapist? _____
To authorize your new Seed of Hope Counseling therapist access to your previous counseling records with us, please sign here: _____

Symptoms currently experiencing:

□ Depressed Mood	□ Racing Thoughts	□ Family Problems
□ Anxious Mood	□ Suicidal Thoughts	□ Relationship Problems
□ Isolation	□ Homicidal Thoughts	□ Academic Problems
□ Poor Concentration	□ Worrying Thoughts	□ Work Problems
□ Crying Episodes	□ Feeling Worthless	□ Hygiene Problems
□ Irritability	□ Sleep Problems	□ Appetite Problems
□ Low Energy	□ Insomnia	□ Food Restriction
□ Low Self-Esteem	□ Hypersomnia	□ Binging
□ Impulsive Behavior	□ Panic Attacks	□ Purging

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?

_____

_____

What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

_____

_____

Who may we thank for referring you to Seed of Hope Counseling? _____