Gilbert Counselors, LLC

Professional Counseling Services

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gilbertcounselors.com

Please complete this form to the best of your ability. Please note "NA" when an item is not applicable to you / your child. For minor children, please also complete the parent questionnaire and the behavior checklist.

If you are completing this form for a dependent child/adolescent of whom you are the legal parent/guardian, please state:
Your name: _____ *DOB:* _____
Relationship to client: _____
Address: _____
Home phone: _____ *Work:* _____
Other: _____
*Is there another parent/legal guardian of this child/adolescent other than someone you currently live with?*_____ *If yes,Name:* _____
DOB: _____ *Relationship to client:* _____
Address: _____
Home Phone: _____ *Work:* _____
Other: _____
What is your relationship with this person? _____
Has this parent been informed of this appointment? _____

A. Identification and Contact Information

Name: _____ Age: _____ Today's Date: _____
Gender: F M
Social Security Number : _____ Date of Birth: _____
Address _____ City _____ Zip _____
Home Phone ( )_____ Work ( ) _____
Cell / other ( ) _____ Preferred number for contact _____
Where may I leave a message? _____
Emergency Contact: Name _____ *Relationship* _____
Phone _____

B. Referral

How did you come by my name? _____
If applicable, who suggested that you contact me? _____
May I have permission to thank this person for the referral? Yes ___ No ___

C. Relationships

Please list current and past marriages or significant romantic relationships

To Whom	Length of Relationship (approximate dates)	Children from Relationship? (names & ages)	Reason Relationship Ended

If currently in a relationship:
Briefly describe the nature of the relationship _____
_____
Partner's Age: ___ Has your partner previously been married? ___ How many Times? ___
How long since partner's last marriage? _____ Does your partner have children from a previous relationship? _____ Names / Ages of children: _____
_____
Education, degrees? _____ Occupation? _____
Is partner currently employed? _____ How long? _____

With Whom are you currently living?

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol / Drugs Mental Illness or Other Problems

Do you have any children who **do not** live with you? _____
Names / Ages:
_____
_____
Do you have any children who **are not** in your custody? _____
Names / Ages:
_____
_____
Do you have any children with whom you share custody with another parent other than someone you currently live with? _____
Name of Parent: _____ Phone number: _____

Extended Family and Friends

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol / Drugs Mental Illness or Other Problems

In a few words, how would you describe your mother? _____
_____your father? _____
_____
How was it to grow up in your family? _____
_____
_____

D. Educational / Occupational / Military

Highest grade / degree completed: _____
Current student? _____ Where? _____ What are you studying? _____
Current Occupation: _____ How Long? _____
Employer: _____ How Long? _____
Address: _____ City, State: _____ Zip: _____
If not employed, how long has it been since you worked? _____
What kind of job did you have? _____
What caused you to stop working? _____
What other types of work have you done in the past? _____
Have you ever been or are you now in the military? _____
Which Branch? _____
What was your specialty? _____
What was your rank at discharge? _____ Honorable Discharge? _____

E. Health / Medical

From whom or where do your receive medical care? _____
Address: _____ Phone: _____
When was your last medical exam? _____
Current health concerns: _____
Are you currently receiving treatment for these concerns? _____
Past health concerns and accidents: _____
_____
List current medications/vitamins/supplements: _____
_____

Women only:

How many pregnancies have you had? _____ Are you pregnant now? _____
Any miscarriages? _____ If yes, how many? _____

Men and Women:
Are you sexually active? _____
Do you use birth control? _____
Do you practice safe sex? _____

Have you ever been concerned about your eating habits? _____ If yes, briefly explain: _____
_____

Have you ever been concerned about your sleep habits? _____ If yes, briefly explain: _____
_____

Do you exercise? _____ If yes, how often? _____ What do you do?
_____

F. Spiritual/Religious Beliefs/Practices: (please answer any or all of the following)
Is Religion or spirituality important to you? _____

Do you consider yourself a spiritual person? _____

Are you affiliated with any particular religion or place of worship? _____
If yes, what is it?_____

What gets you through difficult periods in your life? _____
_____

What brings you hope and joy? _____
_____

G. Treatment
Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? _____ If yes, please indicate:

When?	From Whom?	For What?	With What Results?

Are you thinking about suicide now? _____ If yes, why? _____
_____
Have you ever thought about suicide in the past? _____
Have you ever attempted suicide? _____ If you answered yes to one or both of these, please indicate:

When?	Why?	What did you do?	What happened?

Do you now or have you ever engaged in self-harm (e.g. cutting, burning, or hurting yourself in any way) or other potentially damaging or impulsive behaviors (e.g. unsafe sex practices, gambling, impulsive spending)? _____ If yes, please describe. Include when you started, frequency, what you did, the last time you engaged in the behavior(s) and anything else you think is important for me to know.

_____
_____
_____
_____

Are you now, or have you ever been, the victim or any kind of abuse (emotional, physical, sexual)? _____ If yes, please explain: _____
_____
_____
_____

Do you now or have you ever taken medications for psychiatric or emotional problems? _____
If yes, please indicate:

When	Prescriber	Medication	For What?	Results

H. Chemical Use

Do you believe you have a drug or alcohol problem? Currently? _____ Past? _____
List all tobacco, non-prescribed drugs, and alcohol, that you are currently using or have used in the past:

Type	First Used	Last Used	Amount/Frequency

I. Legal

Please list and describe any arrests or legal issues or problems (include custody): _____
_____
_____
_____

J. Presenting Concern: Please describe the main difficulty or reason you are coming for counseling. Why now?:

_____
_____
_____
_____
_____
_____

Circle any problem that pertains to you at this time:

Nervous	Relaxation	Making decisions	Stress
Shyness	Legal matters	Self-control	Memory
Separation	Energy	Inferiority	Appetite
Drug use	Loneliness	Bowel problems	Marriage
Anger	Education	Sexual problems	Work
Sleep	Undereating	Alcohol use	Overeating
Friends	Concentration	Nightmares	Temper
Fatigue	Ambition	Stomach problems	Divorce
My thoughts	Parenting	Health problems	Age
Finances	My appearance	Suicidal thoughts	Future
Sexual abuse	Children	Career choices	Weight
Unhappiness	Depression	Headaches	Fears
Phobias	Self-esteem	Sexual Orientation	Physical abuse
Anxiety			

Circle everything that has happened to you in the past 3 years:

Death of a spouse/partner	Marriage Problems	Changes in marital status
Death of another family member	Family problems (children, in-laws)	Loss of job
Major illness or injury–yourself	Financial problems	Move
Major illness or injury–family member	Legal problems	Other: _____

Please describe your strengths: _____
_____
Please describe your limitations: _____
_____
Who/What are your supports: _____
_____
Please rate your level of motivation for change (0 to 10 with 10 the highest) _____
Please describe your goals for counseling: _____
_____
_____
Please list any additional information that you believe may be helpful or that you want me to know:
_____
_____
_____