Altus Counseling Services PLLC
Individual and Family Information

Please complete the following information for our first visit. Information you provide is held to the same standards of confidentiality as counseling/therapy described in your consent agreement.

Date: ______________________________

Client name – please print:

____
(Last) (First) (Middle Initial)

If you are a minor, name of legal parent/guardian (legal parent/guardian must also sign a minor consent):

____
(Last) (First) (Middle Initial)

Client birth date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Note: Counseling with minor children of a divorced family requires a copy of a legal divorce decree before a child's individual counseling begins so that I may confirm parental custody and review legal consent having to do with behavioral health services.

Names, ages of spouse, partner, children: ____

____

Phone: ____May I contact you and leave a message? □Yes □No

E-mail ____May I contact you and leave a message? □Yes □No

Note: Appointment notifications require e-mail

Local Address: ____
(Street and Number)

____
(City) (State) (Zip)

May I send mail to this address? □Yes □No

In case of emergency, notify (name and phone contact)

____

Referred by: ____

Briefly state reasons you are seeking counseling now. This might include a description, beginning, symptoms, length and/or frequency of a problem: ____
____
____
____
____

Are you currently receiving psychiatric services, counseling or therapy elsewhere? If so, name of psychiatrist/psychologist/counselor/therapist____

Describe any psychiatric/psychological diagnosis given to you____
____

Have you previously received psychiatric services, counseling or therapy? If so, name of previous psychiatrist/psychologist/counselor/therapist____

Are you currently taking prescribed medical or psychiatric medication or vitamins, or using electro or magnetic therapy devices? If so, please list, including dose, purpose or device (attach separate list as needed)
____
____
____
____

If not now, have you been previously prescribed psychiatric medication? If so, please list
____
____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present? (Check where appropriate)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

List persistent physical symptoms or health concerns, e.g., chronic pain, headaches, allergies, respiratory, hypertension, thyroid, diabetes, apnea, gastro-intestinal, fibromyalgia, or other medical diagnosis
____
____
____
____

Briefly identify treatments you've had in the past for health concerns____________________________________
____
____
____

Are you having any problems with your sleep habits?   If so, check where applicable:
□ Sleeping too little   □ Sleeping too much   □ Poor quality sleep   □ Disturbing dreams

List any medical sleep treatment devices____

How many times per week do you exercise? ______ Approximately how long each time? ________________

Are you having any difficulty with appetite or eating habits? If so, check where applicable:
□ Eating less   □ Eating more   □ Binging   □ Restricting   □ Vomiting

Have you experienced significant weight change in the last 2 months? If so, identify gain or loss: ________lbs.

Do you regularly – most days - use alcohol? If so, in a typical month, how often do you have 4 or more drinks in a 24-hour period? ____

How often do you use recreational drugs?   □ Daily   □ Weekly   □ Monthly   □ Rarely   □ Never

Have you had suicidal thoughts recently?   □ Frequently   □ Sometimes   □ Rarely   □ Never
Have you had them in the past?   □ Frequently   □ Sometimes   □ Rarely   □ Never

Have you self-injured recently?   □ Frequently   □ Sometimes   □ Rarely   □ Never
Have you self-injured in the past?   □ Frequently   □ Sometimes   □ Rarely   □ Never

Are you currently in a romantic relationship or marriage? If so, how long have you been in this relationship?
____

If so, on a scale of 1 (very low) to 10 (very high), rate the quality of your current relationship? _______________

Briefly characterize other current significant relationships and social support in your life now, e.g., relative, friend, child____
____
____
____
____
____
____
____

In the last year, have you experienced life changes or stressors, individually or in family? If so, briefly describe events or challenges related to: work, social, school, relationships, marriage, parenting, health, pregnancy, birth, adoption, children, divorce, military, legal proceedings, death, grief, moving, finances, or others:

____
____
____
____
____
____
____

Have you ever experienced ?(If yes, note in the space below)

Childhood developmental delays
Significant depressed mood
Significant mood swings
Rapid speech
Significant anxiety
Panic
Phobias
Sleep disturbances
Delusions/hallucinations
If yes, briefly describe, and when these occur

Unexplained losses of time
Unexplained memory lapses
Alcohol/substance abuse
Difficulty with appetite or eating habits
Body image concerns
Repetitive thoughts (e.g. obsessions)
Repetitive behaviors (e.g., frequent checking, hand-washing)
Homicidal thoughts
Suicide attempt
Intentional self-Injury
Violent behavior

Head or physical trauma
If yes, just identify event and at what age: ______________________________
____
____
____
____

Psychological trauma

If yes, just identify event and at what age: ____

____

____

____

____

Prior psychiatric/psychological hospitalization

If yes, briefly describe events leading to and length of hospitalization________________________

____

____

Arrest, incarceration, DUI/DWI

If yes, briefly describe events____

____

____

EDUCATIONAL INFORMATION

Highest grade level completed____

Interest - Educational focus____

Briefly describe challenges you may have had with learning during early or later years, e.g., anxiety, test taking, recall, reading comprehension, processing numbers, completing work, focus on work, paying attention

____

____

____

OCCUPATIONAL INFORMATION

Are you currently employed? □ Yes □ No

If yes, who/what is your current employer/position? ____

If yes, on a scale of 1 (very low) to 10 (very high), rate the quality of your current job? _____________________

List work-related stressors, if any: ____

MILITARY SERVICE

If you have served, or are currently serving in the military, identify your

Branch of service_________________________

Highest rank_____________________________

Occupation or specialty, as permitted____

____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? If so, what name/denomination is used to identify your practice

____

If not, do you consider yourself to be spiritual? □ Yes □ No

FAMILY BEHAVIORAL HEALTH HISTORY

Are you (client) adopted into a family? If so, identify country of origin___________________________________

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (note any that applies and list family member, e.g., sibling, parent, uncle, others)

Difficulty	Family Member
Developmental delays	______________________
Attention deficit, hyperactivity	______________________
Depression	______________________
Bipolar	______________________
Anxiety	______________________
Panic	______________________
Schizophrenia	______________________
Alcohol/substance abuse	______________________
Eating challenges	______________________
Learning challenges	______________________
Trauma	______________________
Suicide attempt	______________________
Phobias	______________________
Autism (or previously Asperger's)	______________________

Other or unidentified challenges:

____

____

____

Briefly describe your relationship with parents, siblings, significant others________________________________

____

____

____

____

____

OTHER INFORMATION YOU WANT ME TO KNOW

What do you consider to be your strengths?

What do you consider to be opportunities for growth?

What do you like most about yourself?

Identify effective coping strategies you've learned?

What are your goals for therapy?

What has changed since making this appointment?

What other individuals have you spoken to about this issue?

What else do you want me to know now before we get started?