Hope Healing Joy
Counseling Center, LLC

Client Information:

Name: ______________________________ Date of Birth: ____________

Address: ____________________ City/State: ____________ Zip: ______ Primary

Phone: ________________________________ Cell/Home/Work

Email: ______________________ Soc. Sec. #: _____-_____-______

Gender: __________ Ethnicity: _____________ Race: _____________

Occupation: ____________________ Employer: ___________________

Highest Level of Education: _____________________________________

Marital Status: Married Separated Divorced Widow Single Co-Habit

Name of Spouse/Partner: ____________________ Phone: ____________

Emergency Contact: ____________ Relationship: ________ Phone: ______

Type of Counseling requested (circle one): Individual Couple Family Group

Please contact me by: (initial all that apply)
_____ Texting ______ Leaving a voicemail message ______ Email

Please DO NOT contact me by: (initial all that apply)
_____ Texting ______ Leaving a voicemail message ______ Email

I want to receive email reminders_____ I want to receive text reminders_____

- Yes, I would like to receive free products and information about upcoming events via:
  - Home Address
  - Email

How did you hear about us?

- Internet Search
- Hope Healing Joy Website
- Therapist Finder/Psychology Today
- Referred by: ________________
- Family/Friend recommended
- Other: ____________________

*I understand that texting and email are NOT secure forms of communication and information could possibly be seen by others_______

For office use only: Oral review if intake paperwork______

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Briefly describe the nature of your current problem(s):

____

____

How long have you had the problem(s):

____

Why did you decide to seek help now?

____

What other ways have you tried to deal with this problem?

____

Check any of the following items that apply to you:

	Thoughts of suicide		Thoughts of harming others		Phobias
	Trouble getting to sleep		History of attempts to kill yourself		Panic attacks
	Waking during the night		Cutting or otherwise hurting yourself		Excessive guilt
	Waking early every day		Feelings of hopelessness		Forgetfulness
	Financial problems		Inability to make decisions		Mood swings
	Loss of appetite		Trouble controlling your temper		Health problems
	Hearing voices		Large weight gain or loss		Family problems
	Problems at work		Seeing things others don't		Violence toward others
	Trouble concentrating		History of physical abuse		Tingling or numbness
	Racing thoughts		History of sexual abuse		Depressed mood
	Legal problems		Anxiety		Relationship Issues

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Is there a family history of emotional problems?

____

Family Relationship/Diagnosis:

____

Previous Counseling/Treatment:

(Who): ____________________ (Where): ____________________

(When): ____________________ (Results): ____________________

(Who): ____________________ (Where): ____________________

(When): ____________________ (Results): ____________________

Others Living in the Home:

Name ____________ DOB: ________ School/Employer: ____________

Name ____________ DOB: ________ School/Employer: ____________

Name ____________ DOB: ________ School/Employer: ____________

Primary Care Physician: ____________________ Date of Last Visit: ________

Address: ____________________ Physician's Phone: ____________

List All Current Medications: (Include dosage & length of usage):

____

____

Adverse Reaction to Medications:

____

Allergies:

____

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List any medical problems or physical problems and when they were diagnosed:

____

____

List any major (where you were put to sleep) surgeries you have had to date:

____

____

List any serious illness or injuries especially anything involving the head:

____

____

Check substances you use in ANY amount at all

	Age first used	How much do you use per Weekday	Weekend	Month	Last Used
___ Beer	____	____	____	____	____
___ Liquor	____	____	____	____	____
___ Wine	____	____	____	____	____
___ Marijuana	____	____	____	____	____
___ Cocaine/Crack	____	____	____	____	____
___ Methamphetamine	____	____	____	____	____
___ Heroin	____	____	____	____	____
___ Barbiturates	____	____	____	____	____
___ PCP, LSD	____	____	____	____	____
___ Tobacco	____	____	____	____	____
___ Other________	____	____	____	____	____

Have you ever felt like you should cut down on your drug or alcohol use? Yes No
Has a friend or relative expressed concerns about your use? Yes No
Have you ever felt guilty about your drinking or drug use? Yes No
Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes No
Are you a recovering alcoholic or a recovering drug addict? Yes No
Is there a history of problems with drug or alcohol use in your family? Yes No
If yes, what is their relationship to you? ______________________