Laura Duke, MSW, LCSW

Pre-Counseling Information

THIS INFORMATION WILL REMAIN STRICTLY CONFIDENTIAL

Name: _____ Date: _____

Please tell me why you are here today:

Have you ever had any type of counseling before? _____ Yes _____ No
If yes, please check:

_____Individual Counseling _____Couples Counseling
_____Family Counseling _____In-patient Treatment
_____Group Counseling _____Substance Abuse Help
_____Support Group, type _____

If yes, when was your counseling, who was your therapist, and how long did it last?

Please list any prescription medications or herbal supplements you are taking or have taken in the past:

Please list who is supportive and/or helpful in your life:

Check any significant changes over the last three years:

_____ Deaths _____ Job Loss _____ Relocation
_____ Births _____ Promotion _____ Injuries
_____ Illnesses _____ Marital Status _____ Other

Please explain any of the above:

Please check any issues that are of concern to you:

_____ Relationship issues _____ Eating
_____ Depression _____ Alcohol/Drug Use
_____ Anxiety _____ Work / School
_____ Self-Esteem issues _____ Sexual Concerns
_____ Social Life _____ Spiritual Life
_____ Suicidal Thoughts _____ Finances
_____ Self Harm _____ Legal Involvement
_____ Sexual orientation _____ Other (please specify) _____

Do you have any history of alcohol/drug abuse?_____ yes _____ no
Does your family have any history of alcohol/drug abuse? _____yes _____no
Do you have any history of physical, sexual, emotional abuse, or domestic violence? ____yes___ no