**Libby Rooney, MA, LPC, NBCC**
**8575 W 110th Street, Suite 225**
**Overland Park, KS 66210**
**913-557-0355**

**Client & Family Information**

Please fill out this form completely. If there is information that you do not know, or cannot obtain, write in the word “unknown”. This information will be treated in a strictly confidential way. Date:

Name _____Date of Birth _____ Age ____ Sex ___

If MinorParent/Guardian’s Name
_____
_____
_____

Present address
_____
Number street city state zip
Other address?
_____ Home phone _____
Business or cell phone_____
EMAIL _____
Other phone
_____
Religious Preference:_____To what degree do you want to integrate faith with the counseling?_____

Biological or Adopted: _____ If adopted, age of child at adoption:_____
Ethnic Background:_____
Primary Language spoken in the home_____

_____ Single _____ Married _____Divorce

Who referred you to this office? _____

**Client Information**

Have you had any counseling or are you currently in any type of counseling?
_____

Name, address and phone number of current therapist:
_____
_____

How successful did you find it? Are you currently seeing a psychiatrist?_____

Name, address and phone:
_____
_____

What type of medication(s) do you take?
_____

Why are you taking it?
_____

Does it help?
_____

When was your last physical exam? _____

What were the results?

What is your main concern?

How long has this existed? _____

In what setting does it occur? Home _____ School _____ Sports? _____
Neighborhood? _____ Public places? _____

Has there been any abuse? Physical? Neglect? Sexual?

What do you expect will be different when therapy is completed?

**Illnesses and Diseases**

Please check any illness or disease which you have had.

| | | |
|---|---|---|
| __ asthma | __ tuberculosis | __ dizziness |
| __ eczema | __ heart disease | __ meningitis |
| __ arthritis | __ influenza | __ broken bone |
| __ diabetes | __ pneumonia | __ fainting |
| __ cancer | __ migraine headaches | __ anemia |
| __ undescended testicles | __ measles | __ high blood pressure |
| __ mumps | __ low blood pressure | __ chickenpox __ sinusitis |
| __ diphtheria | __ appendicitis | __ scarlet fever |
| __ heart surgery | __ polio | __ tonsillectomy |
| __cerebral palsy | __ convulsions | __ lead poisoning |
| __ brain injury | __encephalitis | __ other (write in) |

**List any medications you are currently taking:**

**Hospitalizations**

List any hospitalizations, age and length of stay.

| Condition for which hospitalized | Age | Length of stay |
|---|---|---|
| _____ | ___ | _____ |
| _____ | ___ | _____ |
| _____ | ___ | _____ |
| _____ | ___ | _____ |

**Family History:**

Check all of the following family concerns that apply currently or in the last 6 months:
____Marital difficulties
____Children leaving home
____Aging parents
____Recent death in family
____Alcoholism
____Recent death of friend
____Serious illness of child
____Drug addiction in family
____Serious illness
____Financial problems
____ Birth of a child
____Move to a new house
____Traumatic experience
____ New Job

Has there been anyone in your family who has been treated for mental illness?

Or has anyone been on medication for depression, bipolar disorder, or anxiety?

Or has anyone been treated for alcoholism or drugs?

Describe briefly any special interests, hobbies and recreational activities your enjoy:
**List All Those Living in the Home**

Name Relationship Birth date Occupation

Therapist Signature _____ Date_____

IN THE EVENT OF TRANSFERRING, PLEASE FILL OUT:

Transferred to:

_____

_____

_____

Termination date:

_____

_____

_____