High Impact Counseling

Dr. David a hatmaker
P.O. box 1354 Windermere FL 34786

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____

Nick Name:_____ Name You Prefer: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Parent/Guardian: _____ Relationship: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $20,001 to $40,000 ☐ $50,001 to $60,000 ☐ $80,001 to $100,000
☐ $10,001 to $20,000 ☐ $40,001 to $50,000 ☐ $60,001 to $80,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Graduate School:

_____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What School: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Spouses Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):* _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches	☐ Past	☐ Present	Dizziness	☐ Past	☐ Present	Stomach Trouble	☐ Past	☐ Present
Visual Trouble	☐ Past	☐ Present	Sleep Trouble	☐ Past	☐ Present	Trouble Relaxing	☐ Past	☐ Present
Weakness	☐ Past	☐ Present	Tension	☐ Past	☐ Present	Rapid Heart Rate	☐ Past	☐ Present
Difficulty Breathing	☐ Past	☐ Present	Intestinal Trouble	☐ Past	☐ Present	Hearing Noises	☐ Past	☐ Present
Change in Appetite	☐ Past	☐ Present	Tiredness	☐ Past	☐ Present	Pain	☐ Past	☐ Present
Hearing Voices	☐ Past	☐ Present	Seeing Things	☐ Past	☐ Present	Other	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress	☐ Past	☐ Present	Nervousness	☐ Past	☐ Present	Anxiety	☐ Past	☐ Present
Panic	☐ Past	☐ Present	Unhappiness	☐ Past	☐ Present	Depression	☐ Past	☐ Present
Guilt	☐ Past	☐ Present	Apathy	☐ Past	☐ Present	Terminal Illness	☐ Past	☐ Present
Recent Death	☐ Past	☐ Present	Grief	☐ Past	☐ Present	Hopelessness	☐ Past	☐ Present
Inferiority Feelings	☐ Past	☐ Present	Defective Feelings	☐ Past	☐ Present	Loneliness	☐ Past	☐ Present
Shyness	☐ Past	☐ Present	Fears	☐ Past	☐ Present	Friends	☐ Past	☐ Present
Marriage	☐ Past	☐ Present	Communication	☐ Past	☐ Present	Physical Abuse	☐ Past	☐ Present
Emotional Abuse	☐ Past	☐ Present	Verbal Abuse	☐ Past	☐ Present	Sexual Abuse	☐ Past	☐ Present
Temper	☐ Past	☐ Present	Anger	☐ Past	☐ Present	Aggressiveness	☐ Past	☐ Present
Bad Dreams	☐ Past	☐ Present	Concentration	☐ Past	☐ Present	Racing Thoughts	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory	☐ Past	☐ Present	Loss of Control	☐ Past	☐ Present
Impulsive Behavior	☐ Past	☐ Present	Self-Control	☐ Past	☐ Present	Compulsivity	☐ Past	☐ Present
Sexual Problems	☐ Past	☐ Present	Pregnancy	☐ Past	☐ Present	Abortion	☐ Past	☐ Present
Legal Matters	☐ Past	☐ Present	Trauma	☐ Past	☐ Present	Eating Problems	☐ Past	☐ Present
Drug Use	☐ Past	☐ Present	Alcohol Use	☐ Past	☐ Present	Trouble with Job	☐ Past	☐ Present
Career Choices	☐ Past	☐ Present	Ambition	☐ Past	☐ Present	Making Decisions	☐ Past	☐ Present
Children	☐ Past	☐ Present	Being a Parent	☐ Past	☐ Present	Finances	☐ Past	☐ Present
Recent Loss	☐ Past	☐ Present	Disaster	☐ Past	☐ Present	Other	☐ Past	☐ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: □ Yes □ No. Have You Experienced Them in the Past: □ Yes □ No

Have You Ever Attempted Suicide: □ Yes □ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

Please describe your church or religious involvement if any. Would you consider yourself to be a Christian?_____ Are there any special religious, cultural or ethnic considerations we should be aware of?

_____

_____

Do You Have a Personal Support System: □ Yes □ No. If Yes, Who: _____

TERMS OF SERVICE

I hereby give High Impact Solutions and Dr. Hatmaker permission to provide counseling services for the patient mentioned above:

Signed: _____ Date: _____