



Vibrance Counseling, LLC

vibrancecounseling.net

1883 N. Wildwood Way (Building B, Office F) Boise, ID 83713

Phone: (986) 234-3898

Email: amanda@vibrancecounseling.net

Welcome! I am excited to learn more about you so we can begin the healing and helping process. You are the expert on your life and I am honored to be a part of your journey. My office is an accepting and non-judgmental space and I will try my best to show you understanding, compassion, warmth and respect. We will review this form together on the first meeting, where you can ask questions and we can clarify goals for treatment.

Basic Information

Today's Date: _____ Payment: (please circle) Insurance or Private

Name: _____

Address: _____

Date of Birth: _____

Age: _____

Phone number: _____

Ok to leave Voice Mails? _____

Email: _____

Primary Language: _____

Interpreter needed: Yes No

Highest Level of Completed Education: _____

Emergency Contact (name and phone number): _____

What brings you into counseling today: _____



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How would you rate your current mental health? Excellent Good Average Poor Failing

SYMPTOMS:

1.

2.

3.

4.

5.

How do these symptoms affect you in your day to day life?

Mental Health History

Have you ever been in counseling before? YES NO

If yes, what did you find helpful/effective vs unhelpful/ineffective?

Are you currently receiving any mental health services? YES NO

If yes, please list name of practitioner and type of services you are receiving:

What, if any, prior diagnosis have you received?

Have you ever been hospitalized for mental health concerns? YES NO

If yes, list date(s) and length of stay:



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Risk Assessment and Self Harm

Have you ever or are you currently engaging in self harm behaviors?

If yes, what type of self harm and how often?

Have you experienced any of the following:

Extreme depressed mood: YES NO

Extreme mood swings: YES NO

Rapid speech: YES NO

Extreme anxiety: YES NO

Panic attacks: YES NO

Phobias: YES NO

Hallucinations: YES NO

Unexplained losses of time: YES NO

Unexplained memory lapses: YES NO

Eating disorder: YES NO

Repetitive behaviors: YES NO (frequent checking, handwashing, etc)

Homicidal thoughts: YES NO

Suicidal thoughts: YES NO

Suicide attempts: YES NO

Please explain any items which you circled YES:



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Medical History

How would you currently rate your physical health? Excellent Good Average Poor Failing

What, if any, physical symptoms or medical diagnosis do you have?

Are you currently under the care of a medical doctor or other medical health professional?

If yes, name of your Primary Care Physician:

If yes, phone for your Primary Care Physician:

Are you taking any prescription medications? YES NO

Please list:

Are you taking any over the counter medications, vitamins, or herbal supplements? YES NO

Please list:

Basic Living Questions

Do you currently engage in movement/exercise? YES NO

How often and what types of movement/exercise?

How are your sleep habits (routine, amount, rested)?

Are you having any difficulty with appetite or eating habits? YES or NO

Please explain if yes:

Have you experienced significant weight change in the last 2 months? YES or NO

Please explain if yes:



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Vocational History

Are you currently employed? YES NO

If yes, what type of work are you involved in?

Other important facts about your current or past work/school history:

Trauma History

Please indicate if you or an immediate family member experienced any of the following (if a family member please note how related): **If it does not apply to you, please circle (N/A)**

Emotional abuse: (N/A)

Physical abuse: (N/A)

Sexual abuse: (N/A)

Domestic violence: (N/A)

Neglect: (N/A)

Substance abuse: (N/A)

Serious illness: (N/A)

Accident or injury: (N/A)

Legal problems: (N/A)

Frequent/multiple moves: (N/A)

Homelessness: (N/A)

Financial Problems: (N/A)

Other unspecified:

Please explain: