Melanie Arons Counseling and Consulting, LLC
Melanie Arons, MA, LCPC

IDENTIFYING INFORMATION: (Please Print)

Client Name: Parent/Guardian Names, if Client is under 18 years:	Date of Birth:	Insurance Plan:	Group Number:	ID Number:
Address:		City:	State:	Zip Code:
Home Phone: ☐ OK to Call	Cell Phone: ☐ OK to Call		Work Phone: ☐ OK to Call	
E-mail Address	Employer:		Occupation:	

PRESENTING PROBLEMS:

☐ Anxiety/Panic ☐ Social Problems ☐ Anger/Aggression ☐ Life Adjustment/Change ☐ Sexuality/Gender ☐ Behavior Issues

☐ Depression ☐ Addiction/Compulsion ☐ Bereavement/Loss ☐ Family Stress/Divorce ☐ Medical Problems ☐ Legal Problems

☐ Multiple or Single Episode Trauma ☐ Relationship Problems ☐ Other ____________________

ALCOHOL AND OTHER DRUG USE FOR CLIENTS OVER 12 YEARS OLD:

Have you worried about your alcohol or other drug use, either now or in the past? ☐ yes ☐ no
Has anyone in your life ever told you that they wished you would not drink or use drugs (as often)? ☐ yes ☐ no
Has anyone in your family currently have or has had in the past a substance abuse problem and/or an alcohol abuse problem? ☐ yes ☐ no

If yes, please explain____________________

MEDICATIONS AND TREATMENT:

Does the client currently take psychotropic and/or medical medications? ☐ yes ☐ no

Current medications (if necessary, please include additional medications on the back of this page).

__________Reason: __________Dose/Frequency: __________Length of Use: __________

__________Reason: __________Dose/Frequency: __________Length of Use: __________

__________Reason: __________Dose/Frequency: __________Length of Use: __________

Prescribing Doctors(s): ____________________ ☐ Medical ☐ Psychiatrist

____________________ ☐ Medical ☐ Psychiatrist

Has the client seen a therapist before? ☐ yes ☐ no .....If 'yes': was the past experiences positive? ☐ yes ☐ no
Has the client sought treatment for the same issues that are currently being experienced? ☐ yes ☐ no
Previous treatment issues:

MENTAL HEALTH:

Is the client currently experiencing any suicidal thoughts? ☐ frequently ☐ sometimes ☐ rarely ☐ never

Has the client ever intentionally inflicted any harm on themselves? ☐ yes ☐ no (please explain) ____________________

Has the client ever intentionally inflicted any harm on someone else? ☐ yes ☐ no (please explain) ____________________

Has the client ever been hospitalized for mental health issues? ☐ yes ☐ no If yes, please provide when, where and reason: ____________________

YOUR GOAL(S) FOR THERAPY:

1. ____________________

2. ____________________

3. ____________________