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To assist me in helping you, please fill out this form as fully and as openly as possible. All private information is held in the strictest confidence within legal limits. If certain questions do not apply to you, leave them blank. Please print clearly.

Today's Date _____ Date of Birth _____

Name_____ Social Security #_____

Address_____ City_____ Zip_____

Home Phone (Please include cell/pager #'s if available)_____

_____
Current School
_____ Grade_____
Or Last Grade in school Completed_____
Place of Employment_____ How Long_____
Type of Work_____

Are you your own legal guardian (Please circle yes or no)

If not, please indicate the name _____

Other persons or places where we may contact you

Name_____Phone_____

Name_____Phone_____

Who should we contact in case of any emergency? _____
Phone #_____

Who is your family physician? _____Phone_____

Do you have health insurance?_____ Policy #_____

Contact person_____ Phone #_____

Who referred you?_____

For what reason?_____
Are you currently working with other Agencies (MHMR/CPS/Probation/)

Contact person _____Phone _____

Persons currently living with you

Name	**Relationship/Age**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Immediate family members not living with you

Name	**Relationship/Age**
_____	_____
_____	_____
_____	_____

Current general physical health_____

Past hospitalizations, injuries, etc._____

Have you been involved in any mental health counseling:
During ages 1-10 (Please circle yes or no)
When, where, for what reason_____

_____

During ages 11-18(Please circle yes or no)
When, where, for what reason_____

_____

Have you ever undergone any psychological evaluations?_____
If yes, with whom and how long ago_____

Have you ever wanted to or planned to harm yourself or someone else
(Please circle yes or no)
If yes indicate the number of attempts and please describe

_____

_____

_____

Have you used or do you use any of the following (please put yes or no)

Tobacco _____past _____current
Alcohol _____past _____current

List other substance(s)_____

Are you currently taking prescribed medications?

Medication Dosage/Frequency	**Reason**	**Prescribing Physician**

Have you ever had problems with or been bothered by any of the following?

_____Control of anger
_____Concentrating
_____Remembering things
_____Becoming tired easily
_____Getting along with others
_____Depression
_____Anxiety
_____Sleep problems
_____Muscle tension or soreness
_____Uncontrolled or excessive worry
_____Irritability
_____Restlessness (feeling on edge)
_____Mind "going blank"
_____Rapid heart rate
_____Pounding in chest
_____Heartburn or stomach pain
_____Uncontrolled feeling of happiness or euphoria
other_____
_____

Have you ever been a victim of abuse
Physical _____
Sexual _____
Emotional _____

Are there issues that you feel you would like discussed in counseling and areas you would like to change? _____

___ _____

_____

_____

Please answer the following questions. This is an attempt to get to know you better and to identify other areas that may create difficulty for you in counseling/treatment if not known as yet.

Do you have a disability or have you ever been told that you have a disability?
Please circle yes or no
Do you frequently need people to repeat what they have said to you?
Please circle yes or no
Have you ever hit your head and lost consciousness?
Please circle yes or no
Have you ever been unemployed for a long period of time?
Please circle yes or no
Did you ever have special classes or tutoring in school?
Please circle yes or no

In a school or work setting, do you like to learn or learn best by
_____Listening to someone talk
_____Watching someone perform a task
_____Reading on you own
_____Performing tasks yourself
_____Discussing things with another person
_____Discussing things with a group of people
Have you had problems or difficulty with any of the following?
_____Getting your point across to others
_____Sitting Still
_____Focusing on the task at hand for more than several minutes at a time
_____Understanding the point that others are making to you or what others are saying to you
_____Communicating your feelings to others

Thank you for taking the time to complete all areas on this form