CROSSROADS

COUNSELING AND CONSULTATION

CLIENT INFORMATION

Name: _____ Date: _____

Address: _____
Street City State Zip Code

Contact Information: Okay to leave messages?
Home Phone: _____ Yes _____ No_____
Cell Phone: _____ Yes _____ No_____
Email Address: _____
Date of Birth: _____ Social Security Number: _____
Male_____ Female_____ Marital Status: _____

Employer and Occupation: _____

Would you like to receive a Crossroads Counseling & Consultation newsletter with resources for clients at no charge? Yes _____ No_____

If client is a minor, please complete the following:

Client resides with: Mother_____ Father_____ Both_____

Mother's Name: _____ Father's Name: _____

Stepparent(s) Names: _____

Guardians (if different from above): _____

If you are married or have been married:
Name of Spouse: _____ Spouse's Date of Birth:_____

Years married: Present Marriage: _____ Number of marriages:____

For Office Use Only: _____
Therapist Date

Names of Children and Ages (even if not living in your home at this time)

Name	Sex	Age	DOB	Education/Occupation	Living at Home?

CLIENT NAME: _____

Does anyone else live in your home (other than spouse and children listed above):

Name	Sex	Age	DOB	Education/Occupation	Living at Home?

Name and Address of Person Responsible for Payment if Different from Above:
Name: _____
Address: _____
Phone: _____

Emergency Contact:
Name: _____
Address: _____
Phone: _____

How did you learn about Crossroads Counseling & Consultation: _____
_____
_____

Referred by: _____
May we thank them for the referral? Yes_____ No_____

Current Medications:

Name	Dosage	Used for Treatment of:	Prescribing Physician:

Briefly, what difficulties or problems have brought you to seek help at this time?

_____
_____
_____
_____
_____

When did these problems begin: _____

What are your expectations and goals of participating in counseling? _____
_____
_____
_____
_____
_____

Have you attended counseling before? Yes_____ No _____
If so, when and with whom? What was the nature of the counseling?

_____
_____
_____

Have you ever engaged in any self-harm behaviors? If yes, describe and give dates/ages.

_____
_____

Have you ever attempted suicide? If yes, give methods and dates/ages.

_____
_____

Church/Religious Affiliation/Spirituality _____
Have you consulted with your religious professional?_____
Would it be helpful for us to consult with your religious leader? _____

Health Issues (Current):
Appetite: Good____ Average_____ Poor _____
Sleep: Good____ Average_____ Poor _____

Any history of being in a relationship where there was physical, emotional, or sexual abuse?
Yes _____ No_____

Do you use any type of alcohol, drugs, or tobacco? Yes_____ No_____ If yes:

Substance used	Frequency/Amount	Method of Use	First Use	Last Use

Name of Primary Care Physician: _____ Date Last Seen: _____

Name of Psychiatrist: _____ Date Last Seen: _____

Are there any current medical problems?

_____
_____
_____

Family history of health problems? If yes, who and what health problem?

_____
_____
_____

Please list any recent stressful events or changes that have occurred in the last year (accidents, trauma, deaths of friends or family members, marriages, divorces, changes in work, school, residence, etc.)

_____
_____
_____

Any previous mental health hospitalizations? If so, when, how long, and the nature of the hospitalization:

_____
_____
_____
_____

Anything else that would be helpful for the therapist to know:

_____
_____
_____

The above information is accurate to the best of my knowledge.

Client signature: _____ Date: _____

CLIENT NAME: _____

Listed below are some of the common problems/symptoms that people may bring to therapy. Please check all that apply. Rate the ones you check on a scale of 1-10, with 1 being least severe and 10 being most severe.

Check:	Rating:	
_____	_____	Anger
_____	_____	Abuse
_____	_____	Aggression/Violence
_____	_____	Anxiety
_____	_____	Attention/Concentration Issues
_____	_____	Compulsions
_____	_____	Confusion
_____	_____	Depression
_____	_____	Divorce/Separation
_____	_____	Education
_____	_____	Marital Problems
_____	_____	Fear of Specific Objects or Events
_____	_____	Grief/Mourning
_____	_____	Impulsiveness
_____	_____	Financial Problems
_____	_____	Legal Problems
_____	_____	Mood Swings
_____	_____	Family Issues
_____	_____	Problems with Social Relationships
_____	_____	Religious or Spiritual Concern
_____	_____	Self-harming Behavior
_____	_____	Sexual Addiction Issues
_____	_____	Sexual Concern
_____	_____	Thoughts of Suicide
_____	_____	Trouble Making Decisions
_____	_____	Unhappiness
_____	_____	Unwanted/Intrusive Thoughts
_____	_____	Use of Alcohol
_____	_____	Use of Alcohol by a family member
_____	_____	Use of Drugs
_____	_____	Use of Drugs by a family member
_____	_____	Medical/Physical Problems
_____	_____	Work
_____	_____	Other: _____

Client Signature: _____ Date: _____