**Thank you for your time and effort in completing these forms. They provide very valuable information for therapy that helps provide excellence in the counseling process. Your information will be kept private and confidential. Thank you for choosing Eagle Consulting/Counseling Division to assist you in this time of your life.**

|  |
| --- |
| Date: |
| Name: | [ ]  M [ ]  F | Age: | DOB: |
| Occupation: | Education: |
|  |  |
| Relationship Status: | Significant Other’s Name: | Age: |
| Occupation: | Education: |
| How long have you been in your current relationship status? | Have you been married before? |
| Please briefly describe previous marriage: |
|  |
|  |
|  |
| How many children do you have: | Names/Ages: |
|  |
| Step-Children: |
| Grandchildren: |
|  |
| Mother’s Age: | If deceased, how old were you when she passed? |
| Father’s Age: | If deceased, how old were you when he passed? |
| If your parents separated/divorced, how old were you then?  |
| How many siblings do you have? | Names/Ages: |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Briefly describe your current and past relationship with your: |
| Mother: | Father: |
| Step-Mother | Step-Father |
| Please indicate whether any blood relatives have had any of these concerns: |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Parents | Siblings | Grandparents | Aunts/Uncles |
| Depression |[ ] [ ] [ ] [ ]
| Anxiety |[ ] [ ] [ ] [ ]
| Alcohol/Drug  |[ ] [ ] [ ] [ ]
| ADHD |[ ] [ ] [ ] [ ]
| Suicide |[ ] [ ] [ ] [ ]
| Other: |[ ] [ ] [ ] [ ]

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|  |
| Please describe any mental health issues you may have or have had in the past: |
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|  |
| Please list any mental health hospitalizations: |
|  |
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|  |
| Please list any **P**revious and **C**urrent medications prescribed: |
| Name of Medication/Provider | Dosage | Side Effects: |
| [ ]  **P** [ ]  **C** |  |  |
| [ ]  **P** [ ]  **C** |  |  |
| [ ]  **P** [ ]  **C** |  |  |
| [ ]  **P** [ ]  **C** |  |  |
| [ ]  **P** [ ]  **C** |  |  |
|  |  |  |
|  |  |  |
| Describe any current or past legal issues: |
|  |
|  |
|  |
| Describe any current or past alcohol or drug abuse: |
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| What is your religious affiliation? |
| Do you desire to have your religious beliefs and values incorporated into the counseling process? |
|  |
| What are your hobbies or things you enjoy doing in your life: |
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| Please describe the concerns that you would like to discuss with your counselor: |
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| How long has this problem persisted? |
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| Under what conditions do your problems get worse? better? |
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| Please describe your experience with any previous counseling: |
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| What are your expectations/goals from the counseling process? |
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| ***Symptom Checklist*** |
| **Of the following, check those that apply (use a “P” to designate to past problems, a “C” to note a current issue, and a blank for no problem.**  |
|

|  |  |  |
| --- | --- | --- |
| [ ]  difficulties with children | [ ]  panic attacks | [ ]  fear of disapproval |
| [ ]  difficulties with spouse | [ ]  physical abuse | [ ]  difficulty saying “no” |
| [ ]  emotional/physical affair | [ ]  emotional abuse | [ ]  weight/diet issues |
| [ ]  trouble with memory | [ ]  perfectionism | [ ]  trouble sleeping |
| [ ]  trouble with concentration | [ ]  difficulty trusting others | [ ]  recurrent flashbacks |
| [ ]  fatigue/low energy | [ ]  guilt/shame | [ ]  angry outbursts |
| [ ]  excessive energy | [ ]  low self-esteem | [ ]  aggressive/violent behaviors |
| [ ]  confusion | [ ]  withdrawn, isolating | [ ]  school/work problems |
| [ ]  grief | [ ]  depressed mood/sadness | [ ]  financial difficulties |
| [ ]  sexual problems | [ ]  loss of hope | [ ]  pornography |
| [ ]  fears/phobias | [ ]  mood swings | [ ]  self-injury |
| [ ]  anxiety/worry/nervousness | [ ]  fear of failure | [ ]  alcohol/drugs |
| [ ]  Other: |
|  |

 |
| **Of the following, check those that apply (use a “P” to designate to past problems, a “C” to note a current issue, and a blank for no problem.**  |
|

|  |  |  |
| --- | --- | --- |
| [ ]  neurological impairment | [ ]  irregular menstrual periods | [ ]  tuberculosis |
| [ ]  seizure disorder | [ ]  musculoskeletal condition | [ ]  obesity |
| [ ]  visual loss/impairment | [ ]  HIV/AIDS/related condition | [ ]  significantly underweight |
| [ ]  hearing loss/impairment | [ ]  cancer | [ ]  cirrhosis |
| [ ]  dementia  | [ ]  thyroid disease | [ ]  hepatitis |
| [ ]  GI disorder  | [ ]  diabetes | [ ]  heart condition |
| [ ]  asthma  | [ ]  chronic bronchitis | [ ]  hypertension |
| [ ]  pregnancy | [ ]  emphysema | [ ]  allergies |
| [ ]  Other: |
|  |

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| Who is your primary care physician? |
| Please list any medical hospitalizations you have had: |
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**Thank you so much for completing these forms. We want your therapy process to be successful. Please feel free to ask your counselor any questions you may have at any time. Thank you for choosing and trusting Eagle Consulting/Counseling Division to make a difference in your life!**

**www.eaglecounselingtec.com**