Intake Questionnaire For New Patients

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide will be confidential as required by state and federal law.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular/Alternative Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: single married separate divorced

Remarried engaged widowed cohabitating

If applicable, please complete the following:

Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner’s Age: \_\_\_\_\_

Partner’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Name** | **Sex** | **Age** | **#** | **Name** | **Sex** | **Age** |
| **1** |  |  |  | **4** |  |  |  |
| **2** |  |  |  | **5** |  |  |  |
| **3** |  |  |  | **6** |  |  |  |

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adult and children):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Name** | **Relation** | **Sex** | **Age** | **#** | **Name** | **Relation** | **Sex** | **Age** |
| **1** |  |  |  |  | **4** |  |  |  |  |
| **2** |  |  |  |  | **5** |  |  |  |  |
| **3** |  |  |  |  | **6** |  |  |  |  |

In your own words, describe the current problems as you see them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What made you come in at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to gain from counseling?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you had difficulties in the past, what have you done to cope? Was it helpful?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms:**

Please check any symptoms or experiences that you have had in the last month

Difficulty falling asleep  Difficulty staying asleep

Difficulty getting out of bed  Not feeling rested in the morning

Average hours of sleep per night: \_\_\_\_\_\_\_\_\_\_\_

Persistent loss of interest in previously enjoyed activities

Withdrawing from other people  Spending increased time alone

Depressed mood  Feeling Numb

Rapid mood changes  Irritability

Anxiety  Panic attacks

Frequent feelings of guilt  Avoiding people, places, activities or specific things

Difficulty leaving your home

Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands) Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outburst of anger

Worthlessness  Hopelessness

Eating more  Eating less

Voluntary vomiting  Use of laxatives

Excessive exercise to avoid weight gain  Binge eating

Are you trying to lose weight? \_\_\_\_\_\_\_\_\_\_

Weight gain: \_\_\_\_\_\_ lbs.  Weight loss: \_\_\_\_\_\_\_ lbs.

Difficulty catching your breath  increase muscle tension

Unusual sweating  easily started feeling “jumpy”

Increased energy  Decreased energy

Tremor  Dizziness

Frequent worry  Physical sensations others don’t have

Racing thoughts  Intrusive memories

Difficulty concentrating or thinking  Large gaps in memory

Flashbacks  Nightmares

Thoughts about harming or killing yourself  Thoughts about harming or killing someone else

Feeling as if you were outside yourself, detached, observing what you ae doing

Feeling puzzled as to what is real and unreal

Persistent, repetitive, intrusive thoughts, impulses, or images

Unusual visual experiences such as flashes of light, shadows

Hear voices when no one else is present

Feelings that your thoughts are controlled or placed in your mind

Feeling that the television or the radio is communicating with you

Difficulty problem solving  Difficulty meeting role expectations

Dependency on others  Manipulation of others to fulfill your own desires

Inappropriate expression of anger  Self-mutilation/cutting

Difficulty or inability to say “no” to others  Ineffective communication

Sense of lack of control  Decreased ability to handle stress

Abusive relationship  Difficulty expressing emotions

Concerns about your sexuality

Sexual Orientation:  Heterosexual  Homosexual  Bisexual  I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

No  Yes If so:

Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **CCURENTLY** taking P**SYCHIATRIC** medication:  No  Yes If YES, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **How long have you been taking it?** | **Has it been helpful?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication?  No  Yes If YES, please list:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **How long have you been taking it?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you been on P**SYCHIATRIC** medication in the past?  No  Yes If YES, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **How long have you been taking it?** | **Has it been helpful?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you been hospitalized for psychiatric reasons?  No  Yes If YES, please list:

|  |  |  |
| --- | --- | --- |
| Hospital | Dates | Reason |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever attempted suicide?  No  Yes If YES, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Are you CURRENTLY under treatment for nay medical conditions?  No  Yes If YES, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any PRIOR illnesses, operations and accidents

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Father: Age: \_\_\_\_\_\_  Living  Deceased Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequently of contact with him: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you/Have you been close to her? \_\_\_\_\_\_\_\_\_\_\_

Mother: Age: \_\_\_\_\_\_  Living  Deceased Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequently of contact with him: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you/Have you been close to her? \_\_\_\_\_\_\_\_\_\_\_

*Brothers and Sisters*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Sex** | **Age** | **Whereabouts** | **Are you close to him/her?** | |
|  |  |  |  | NO | YES |
|  |  |  |  | NO | YES |
|  |  |  |  | NO | YES |
|  |  |  |  | NO | YES |

**Please place a check mark in the appropriate box if these are or have been present in your relatives**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Children** | **Brothers** | **Sisters** | **Father** | **Mother** | **Uncle/Aunt** | **Grandparents** |
| **Nervous Problem** |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |
| **Hyperactivity** |  |  |  |  |  |  |  |
| **Counseling** |  |  |  |  |  |  |  |
| **Psychiatric Medication** |  |  |  |  |  |  |  |
| **Psychiatric Hospitalization** |  |  |  |  |  |  |  |
| **Suicide Attempt** |  |  |  |  |  |  |  |
| **Death by Suicide** |  |  |  |  |  |  |  |
| **Drinking Problem** |  |  |  |  |  |  |  |

**SOCIAL HISTORY**

*Past Marital History*

Have you bee married previously? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Yes, please describe

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Education*

Highest grade level completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree obtained, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any disciplinary problems in school? \_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you considered hyperactive/ADHD in School? \_\_\_\_\_\_\_\_

If yes, were/are you on any medication? \_\_\_\_\_\_\_\_\_

If yes, were/are you on any medication? \_\_\_\_\_\_\_\_\_

If so, which medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of grades did you get in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you served in the military? \_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe briefly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of discharge (separation) did you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employment*

Are you currently employed? \_\_\_\_\_\_\_\_\_\_\_\_

If yes, employer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment History (most recent first)**

|  |  |  |
| --- | --- | --- |
| **Type of Job** | **Dates** | **Reason for Leaving** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you been arrested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a religious affiliation? \_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of social activities do you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you turn to for help with your problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been abused?

Verbally  Emotionally  Physically  Sexually  Neglected

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE ABUSE**

*Alcohol*

Do you drink alcohol? If yes, age of your first use: \_\_\_\_\_\_\_\_

How much do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever passed out from drinking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever blacked out from drinking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the “shakes” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt you should cut down on your drinking/drug use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have people annoyed you by criticizing your drinking/drug use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt back or guilty about your drinking/drug use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever drank/used drugs in the morning to steady your nerves or relive a hangover? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Drugs:

Please indicate for each drug listed below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug** | **Ever Used?** | **Age at 1st use** | **Time Since Last Use** | **Approximately use in last 30 days** |
| Marijuana |  |  |  |  |
| Cocaine |  |  |  |  |
| Crack |  |  |  |  |
| Heroin |  |  |  |  |
| Methamphetamine |  |  |  |  |
| Ecstasy |  |  |  |  |

Is there anything else you would like us to know about you?

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**Andrea Griggs, M.Ed., LPC, CCTP, NCC**

Houston Center for Training and Supervision

1235 North Loop Freeway W, Suite 918 Houston, Texas 77008

**Qualifications**

I obtained a Master of Education with a concentration in Clinical Mental Health Counseling from Lamar University and a Bachelor of Art in Sociology with a minor in Psychology from Texas A&M University. I am a Licensed Professional Counselor. My formal education has prepared me to counsel individuals, groups, couples, families, adolescents, and children.

I am a member in good standing of the American Counseling Association, Association for Humanistic Counseling, Texas Counseling Association, Texas Association for Humanistic Education & Development, Houston Counseling Association, and Chi Sigma Iota.

**Theory of Counseling**

There are many counseling approaches and techniques which may be utilized at any given time to meet a client’s specific needs. My counseling approach is based on a combination of Solution-Focused Brief Therapy, Reality/Choice Therapy, and Cognitive Behavioral Therapy. Solution-Focused Brief Therapy is based on the optimistic assumption that people are competent and able to construct solutions that can enhance their lives. You will have the opportunity to describe your problems, set goals for yourself, and offer feedback. The goal of Reality/Choice Therapy is to help people become more effective in meeting their needs; to enable clients to get reconnected with the people they have chosen to put into their quality worlds and teach clients choice theory. Cognitive Behavioral Therapy involves a learning process where clients acquire and practice new skills; learn new ways of thinking, and more effective ways of coping with problems. I will ask that you complete homework assignments, as I believe that the work we do in session will be most effective if implemented in your life outside of therapy.

**Nature of counseling**

* Sessions are held one time per week for 50 minutes.
* The counseling relationship is a professional relationship rather than a social one. You will best be served if our sessions concentrate solely on your concerns. Gifts are discouraged and will not be accepted.
* Our contact will be limited to the counseling sessions you arrange with me at the Houston Center for Training and Supervision office.
* Please note that it is not possible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.
* If I see you in public, I will protect your confidentiality by not approaching you first, nor will I discuss your case with you in public.
* If you should need to contact me, I may be contacted by telephone at **281-940-8042** or email at **andreagriggstherapy@gmail.com**. Contact via social media (Facebook, LinkedIn, Twitter, etc.) is strictly prohibited.

**Client Rights**

* It is your right at any time to inquire about the process and procedures being used during our counseling relationship. You have the right to refuse or request changes to any of my suggestions. If at any time you are not satisfied with my services for any reason, you can inform me or the board of licensed professional counselors.
* Once you have begun counseling with me, there is no obligation to continue. You have the right to discontinue at any time, though I ask that you participate in a termination session. Should you desire a referral to another therapist, I will provide you with one.
* My services are rendered in a professional manner consistent the ethical standards of the American Counseling Association. If you have a complaint concerning malpractice, this can be reported to the board of licensed professional counselors.

**Confidentiality**

Everything we discuss in sessions will be kept confidential, except:

1. If I determine you are in imminent danger to yourself or to others;
2. If you disclose child or elder abuse/neglect;
3. If your records are subpoenaed by a court of law;
4. If you disclose sexual contact with a mental health provider with whom you have had a professional relationship;
5. If I am directed by you in writing to disclose information to someone of your choosing;
6. If you bring a malpractice suit against me

If you are experiencing an emergency situation, please go to the nearest emergency room, or call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or for free 24 hour hotline support, the Harris County Crisis Line at 713-970-7000 press option 1.

In order to provide you with the best possible services, I may discuss the details of your case with my site supervisor, Robin, who is a licensed professional counselor (LPC) and a licensed professional counselor supervisor (LPC-S).

By your signature below, you are indicating that you have read, understand, and agree to this agreement.

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Client/Legal Guardian Signature Date

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Counselor Signature Date

**Houston Center for Training and Supervision**

**Counseling Fee Agreement**

Houston Center for Training and Supervision is committed to providing affordable counseling services to the community. In an effort to do that, counseling services are provided to individuals, couples, families, and groups.

**A fee of $**\_**100.00\_ per session has been assessed for counseling services that you receive at the Houston Center for Training and Supervision.** Please be prepared to pay your counseling fee at the time of your counseling sessions. Checks, Zelle, Venmo, money orders, cash, and card are all acceptable forms of payment. If at any point financial circumstances arise that make counseling unaffordable at the above agreed upon rate, please inform Andrea Griggs and the fee can be reassessed on an individual basis.

During the course of your counseling, I ask that you be considerate of my time and that of other clients. Consistent attendance can make the difference between successful and unsuccessful treatment. I take seriously our commitment to help each client achieve their goals. In order to fulfill that commitment, I ask that all clients adhere to the following policies:

* 24-hour’s notice is required to cancel or reschedule an appointment without penalty. Even if you are unable to provide 24-hour’s notice, please contact Andrea Griggs as soon as possible if you must cancel an appointment or if you will be running late.
* No Shows or Late Cancellations will be charged the regular session fee and should be paid at the next session.
* If you are late for your scheduled session, you may not be seen. If seen, the session will end at the regular scheduled time and you will be charged the regular session fee.

By signing this agreement you agree that you have read the above information and agree to adhere to any policies put forth under the counseling program.

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| Client(s) Name(s) – print |  |
| If client is a minor child, name of parent/legal guardian bringing child in for services |  |
| Signature of client(s) or Parent/Legal Guardian |  |
| Date Signed |  |