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Clients Information:

Family Members Names:	Date of Birth:	Living in the Home: Yes/No	Will they be attending counseling?: Yes/No	Employer or School Attending:

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____Can I contact you at this email address? Yes No

Home Phone: _____ Can messages be left at this number? Yes No

Cell Phone: _____ Can messages be left at this number? Yes No

Other Phone Number:_____ Can messages be left at this number? Yes No

Financial Responsibility:

Who is financially responsible for services? _____

Insurance Company: _____

Insurance Company Address: _____

Policy Holder's Name: _____

Policy Holder's Social Security # : _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Policy Holder's Employer: _____ Work Phone Number: _____

Family Members:	Physician:	Date of last physical:	Any Medical conditions or concerns (thyroid, allergies, hospitalizations ,disease, etc.):	Describe and current or previous substance abuse including alcohol and tobacco.

Medical /Mental Health History: (Provide information for family members attending counseling.)

Please list any medications (prescription or nonprescription) that family members are currently taking:

Family Member:	Medication:	Dosage:	Date Began:	Date Ended:	Prescribing Physician:

Please provide information regarding previous treatments (counseling, occupational therapy

Family Member:	Provider	Dates of Service:	Purpose:

Does any family member have a history of physical/sexual/emotional abuse? Yes No

Has any family member been given a mental health diagnosis? Yes No

Has any family member had a suicide attempt? Yes No

Please circle any of the following symptoms/conditions that family members are experiencing and indicate which family member:

Headaches _____

Dizziness _____

Head Injury _____

Fatigue _____

Heart Trouble _____

Irritability _____

See or Hear Things that are not There _____

Weight Gain or Loss _____

Thoughts of Self Harm _____

Depression _____

Learning _____

Diabetes _____

Abuse _____

Sexual Behavior Problems _____

Anemia _____

Allergies _____

Legal Problems _____

Stress _____

Anxiety _____

Feeling Out of Control _____

Difficulty Sleeping _____

Rituals _____

School Problems _____

Difficulties Making Friends _____

Repetitive Behaviors _____

Difficulty with Change _____

Defiance _____

Hyperactivity _____

Difficulty with Attention _____

Poor Boundaries _____

Restricted Interest _____

Difficulty _____

Thyroid Problems _____

Please list/describe any other medical disease / condition of family members that is not listed above:

_____

Other:

What are your reasons for seeking counseling/parenting services at this time?

_____

_____

Is there anything else you would like to share that was not asked above?

_____

_____

How were you referred to Capitol Peak Counseling or Jennifer Worcester?

_____

This form is being completed by:_____