Holistic Counseling Services

BIOGRAPHICAL DATA

All information is strictly confidential – The Practice will not release this information or contact anyone listed below without your written consent.

1. Name: Last First MI	2. Age:	3. DOB	4. Sex ☐ Male ☐ Female
5. Mailing Address			
6. Home Phone: Cell: Work Phone:			
7. Email Address:			
8. Spouse's Name:			
9. Home Phone: Cell: Work Phone:			
10. Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Separated ☐ Living together ☐ Widowed ☐ Divorce & Remarried ☐ Divorced & Living together		11. Occupation/Employer	
12. Education: Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 ☐GED ☐High School Diploma ☐Some College ☐BS/BA ☐Some Graduate ☐MS/MA ☐ Ph.D.		13. Veteran ☐ Yes ☐ No	Spouse ☐ Yes ☐ No

FAMILY HISTORY

Family Member	Age	Living Yes	Living No	Occupation/ School
Spouse's Name: (If Different)				
Mother's Name:				
Father's Name:				
Brothers/Sisters of person completing form:				
Brothers/Sisters of person completing form:				
Brothers/Sisters of person completing form:				

Name of Child #1:				
Child # 2:				
Child # 3:				
Additional Children:				
Who can we notify in case of emergency	Relation To You:	Address:		Phone Number:

INSURANCE INFORMATION

Subscriber Name	DOB:	Insurance Company/HMO	Member ID#	Group #

Subscriber if other than Client	DOB:	Insurance Company/HMO	Member ID#	Group #

MARRIAGE INFORMATION

Is your spouse willing to come to counseling?	Yes	No	Uncertain
Have you ever been separated	Yes	No	
Separated when? From what dates?			

REFERRAL INFORMATION: Who referred you to this practice? (Check all that apply)

	Self		Friend		Mental Health Professional	
	Family/Relative		Primary Care Physician (PCP)		Employee Advisor Program	
	Advertisement/Brochure		Other (Specify):			

Have you been treated for mental health or substance abuse before? ☐ Yes ☐ No When (Dates?) _____ With whom? _____
If yes, what was the outcome?
Have you been treated for mental health or substance abuse before? ☐ Yes ☐ No When (Dates?) _____ With whom? _____
If yes, what was the outcome?
Is this your first request for services with our group? ☐ Yes ☐ No

Briefly Answer the Following Questions

(Only answer this page if you are interested in receiving Christian counseling)

Are you interested in receiving Christian counseling? ☐ Yes ☐ No (If No, skip this page)

Do you belong to a church? ☐ Yes ☐ No If yes, name of church_____

What is your religious preference?_____

How often do you attend church per month?_____

What is the religious background of your spouse *(if married)*? _____

Are you saved? ☐ Yes ☐ No

Have you come to the spiritual place in your life where you can say that you know for certain that if you were to die tonight you would go to heaven? ☐ Yes ☐ No

Have your gone to your Pastor for counseling? ☐ Yes ☐ No

Have you had any Biblical Counseling before? ☐ Yes ☐ No

If yes, please explain _____

Is there any other information we should know? _____

Presenting Problem:

What brings you here today? _____

What have you done about it? _____

MEDICATION HISTORY

List all medications you are taking (including over the counter medicines)? Drug Dose/Frequency Have you ever had a drug allergy or sensitivity? ☐ Yes ☐ No If yes, which drug(s)	Who is your Primary Care Physician (PCP)? Name_____ Phone or Location_____ Is your physician aware of this referral? ☐ Yes ☐ No
When was your last physical exam?	What is your height? _____ Weight? _____

FAMILY MEDICALHISTORY

Have any of your blood relatives suffered from the following disease(s) or problem(s)?

	Please Circle	Who?
High blood pressure	☐ Yes ☐ No	
Heart disease	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Diabetes (sugar)	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Tuberculosis (TB)	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Sickle Cell Anemia	☐ Yes ☐ No	
Nervous/Emotional Problems	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Other (Please specify)	☐ Yes ☐ No	

PERSONAL MEDICAL HISTORY

High blood pressure	☐ Yes ☐ No	Ulcer/Gastritis	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No	Head Injuries	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Epilepsy/Seizure	☐ Yes ☐ No
Diabetes (sugar)	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice/Liver	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Sexually Transmitted diseases: Syphilis, gonorrhea, chlamydia, NGU	☐ Yes ☐ No	Thyroid/Endocrine	☐ Yes ☐ No

HEALTH INFORMATION

Rate your health:				
Very Good	Good	Average	Declining	Other: (explain)

Your approximate weight (lbs.)	Recent weight loss (lbs.)
Recent weight gain (lbs.)	Height
List all information present or pass illness, injuries, or handicaps:	
Date of last medical examination:	Report:
Your Physician:	Address:

Are you presently taking medication?	Yes	No	What type?
Have you ever used drugs for non-medical purposes?	Yes	No	What?
Have you ever been severely emotionally upset?	Yes	No	Explain
Have you ever been arrested?	Yes	No	Explain
Are you willing to sign a release of information so that your counselor may write for social, psychiatric or medical reports?	Yes	No	Explain

The questions below are optional:

☐African-American ☐Asian ☐Hispanic ☐White ☐Native American ☐Others	Income:	☐$0-5,000	☐$20,001-25,000
Email address:_____		☐$5,001-10,000	☐$20,001-50,000
You: _____		☐$10,001-15,000	☐$50,001-75,000
Spouse: _____		☐$15,001-20,000	☐$75,000 +
Other:			

DO NOT WRITE BELOW THIS LINE

Section to be completed by Practice Staff

Therapist _____ Date _____

Refer to Primary Care Physician:

Clients:

_____

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Notes:

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Revised July 24, 2012