Family Resource Center
Prevent Child Abuse Habersham

Name____Today's Date _________________________

Date of Birth___________________Age:__________Email address*: ________________________________

Home Address_____________________________________City_____________________ZIP__________

Phone Numbers: Home__________________Cell____________________Work ____________________

Please indicate whether I may leave a message: Home phone Y / N Cell phone Y / N Work phone Y / N

Calls will be discreet, but please indicate any restrictions: _______________________________________

Name of Employer______________________________________Occupation: _______________________

Address of Employer:______________________________City_____________________ZIP__________

Highest Education Completed (circle): Some High School High School Associates Bachelor Post Grad

Who referred you to this office? ____

If referred by a doctor or another clinician, would you like for us to communicate with one another? Y / N

Person(s) to notify in case of any emergency:_________________________Phone:___________________

*Please note: I will only contact this person if I believe it is a "life-or-death emergency." Please provide your signature to indicate that I may call if necessary: (Your signature):____________________________

Counseling Questions:

Have you ever received counseling or consulted a psychiatrist, psychologist or mental health professional? Y / N

If so, approximately when & with whom?____

Did you find counseling helpful? ____

Reason you terminated counseling ____

Please briefly describe the main reason for your visit today? ____

____

____

What would your life be like if this problem were no longer an issue for you? ______________________________

____

____

What are your goals for therapy? ____

____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? ____

Medical History:

Please explain any significant medical problems, symptoms or illnesses: ____________________________

____

Previous medical hospitalizations (approximate dates and reasons):________________________________

____

Previous psychiatric hospitalizations (approximate dates and reasons): ______________________________

____

Current medications (use back of form if more space is needed):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Approximate Height:_____________Approximate Weight:________________Gender: _________________

Briefly describe your diet and exercise patterns: ____

____

Do you smoke or use tobacco? Y / N If yes, how much per day? ____

Do you consume caffeine? Y / N If yes, how much per day? ____

Do you drink alcohol? Y / N If yes, how much per day? ____

Do you use any non-prescription drugs? Y / N If yes, what kinds and how often? ___________________________

Have any of your friends or family members voiced concern about your substance use? Y / N

Have you ever been in trouble or in risky situations because of your substance use? Y / N

Mental Health Symptoms:

Please indicate any symptoms past & present on a scale from 0 (never) to 5 (all the time/severe):

DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past	DIFFICULTY WITH	Now	Past
Depression			Anxiety			Intense Fears		
Feeling Hopeless			Irritability			Nightmares		
Loss of Interest			Agitated/Restless			Feeling Numb/Detached		
Sleep too much			Fidgety			Easily Startled		
Sleep too little			Angry/Resentful			Obsessive Thoughts		
Excessive weight gain			Argumentative			Repetitive Behaviors		
Excessive weight loss			Dizziness			Overly Stressed		
Low Energy/Fatigue			Headaches			Sexual Concerns		
Memory Loss			Shortness of Breath			Domestic Violence		
Poor Concentration			Chills or Hot Flashes			Legal Problems		
Social Isolation			Heart Racing/Chest Pain			Financial Problems		
Grief			Muscle Tension			Drug Use		
Mood Swings			History of Head Injury			Alcohol Use		
Episodes of Crying			Blackouts			Chronic Pain		
Thoughts of Death			Completing Tasks			Problems at Work		
Self Mutilation/Harm			Hyperactive			Problems at Home		
Suicide Attempt			Paying Attention			Problems with Friends		
Thoughts of Hurting Someone Else			Easily Distracted by Noise			History of Abuse/Neglect		

Family, Relationships, Social Support & Self-Care:

Mother's age (or age at death)_______How would you describe your relationship with your mother?_____________

____

Father's age (or age at death) _______ How would you describe your relationship with your father?_____________

____

If alive, are your parents still married Y / N If they are divorced, how old were you when they separated or divorced, and how did this impact you? ____

Were there any other primary care givers who you had a significant relationship with? If so, please describe who

and how this person impacted your life:____

____

How many sisters do you have? ______ Ages/names? ____

How many brothers do you have? ______ Ages/names? ____

How would you describe your relationship with your siblings? ________________________________

____

Briefly describe any history of abuse, neglect and/or trauma:_________________________________

____

Please indicate if there is a family history of any of the following (if there is, please indicate the family member's relationship to you: father, grandmother, uncle, etc): Alcohol/substance abuse, anxiety, bipolar disorder, depression, domestic violence, eating disorders, hyperactivity, learning disabilities, legal trouble, "nervous breakdown," obesity, obsessive compulsive behavior, sexual abuse, schizophrenia, suicide attempts, trauma.

____

____

Poor Excellent

Currently in a relationship? Y / N If yes, for how long?__________Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? Y / N If yes, for how long?__________Name of partner______________________

Occupation of partner___________________________Employer ____________________________

Previously Married/Life Partnered? Y / N If yes, length of previous relationship(s) ____________________

Do you have children? Y / N If yes, list names/ages: ____

Describe any problems any of your children are having: ____

____

List the names/ages of those living in your household: ____

____

Current level of satisfaction with your friends and social support (1=poor, 7=excellent): 1 2 3 4 5 6 7
Please list the names of those you consider your close friends who you can lean on in times of distress:

____

What are some of your strengths? ____

____

Is spirituality important in your life? Y / N Please explain: ______________________________________

____

Final Question:

Is there anything else I should know about you and/or your circumstances before we begin our work together? If so, please specify: ____

____

____ ______________________

Signature (guardian, if client is unable to sign) (Date)