Alternatives in Counseling, Inc. Date: ______________________

Everything that is said and done in the counseling session shall be considered confidential.
According to and in compliance with to HIPAA regulations, disclosure will not occur without the demonstration of Medical Necessity. Disclosure will be in compliance with the Minimum Necessary principle to ensure safety and appropriate protection in agreement with the Duty to Warn as for all mandated reporters. Initial: ___________
I received State Required Professionals Notification. Initial: _________ __________
I have signed the Members Rights and Responsibilities Statement. Initial: ________ ___________
I have read and signed the Client/Patient Technological Communication Agreement. Initial _________ __________
I have been given the option to coordinate care with the Primary Care Physician. Initial: _________ __________
I hereby authorize and consent to treatment.

____________________________________ ____

Counselee Signature and Date Interviewer Signature and Date

____________________________________ ______________________________ _____________

Others Attending Signature and Date Emergency Contact Person & Number

ABOUT YOU

Insured Social Security (required by Insurance)__________________

Name ____________________________________ Gender ______ Birth Date ______________________ Age ___________

Street Address ____ City, State __________________ Zip __________

Safe Numbers: Home ______________ Work ________________ Cell _____________ Email ___________________________

Employer ____ Occupation _______________________________________

How long have you been at this job? _______________________ How long were you at your previous job? __________

Current Marital Status: Single _____ Married _____ Divorced _____ Widow (er) _____ Committed Relationship _____

Who referred you to *Alternatives in Counseling?* ____

ABOUT YOUR HEALTH

Please rate your health: Very Good ______ Good ______ Average ______ Declining ______ Special Needs _____________
Please explain:

____

List all important present or past illnesses, injuries, or handicaps: ____

____

Types of exercise, activities, intetrests:____

Have you had any recent changes in weight? _______________________ Approximate weight gain/loss _____________

Sleep Pattern: _____ Get a good night's rest _______ Can't get to sleep _____ Wake-up, can't go back to sleep ______

Other, explain: ____

Your Physician: ____ Phone ___________________________________

Date of last medical examination: __________ Report ____

Circle any of the following symptoms that currently apply to you. Add any not listed.

Depression Anxiety/Panic Mood swings Difficulty concentrating Anger outbursts Compulsive behavior
Addiction Binge eating Vomiting/purging Laxative use Chronic fatigue Nightmares Flashback
Loss of interest in sex Hyperactive or compulsive sexual feelings or actions Compulsive gambling Other ______

Are you presently taking prescribed medications? ____ List medications/drugs (dosage, how long, prescribed by):

____

____

____

Vitamins, nutrients, supplements ____

____

ARE YOU:	
Pregnant? *Yes No Not Applicable*	*Due When?* ______________________
Experiencing menstrual cycle difficulties? *Yes No NA*	*Describe:* ______________________
Using caffeine? *Yes No NA*	*Describe:* ______________________
Nicotine use? *Yes No NA*	*How much daily?* ______________________
Using recreational drugs? *Yes No NA*	*What? How much and often?* ______________
Drinking Alcoholic beverages? *Yes No NA*	*What? How much and often?* ______________

Have you ever had psychotherapy or counseling before? ____

Have you ever been psychiatrically diagnosed? ________ Diagnosis ________________________________

If yes, please name psychiatrist, psychologist, or therapist and dates: ______________________________

____

Are you willing to sign a Release of Information form so we may obtain your records? __________________

Have you ever seriously considered suicide? _________ Are you currently having suicidal thoughts? ____________

Have you ever-heard voices or seen things that were not there? _____ Explain __________________________

What support networks do you use? (Circle and add others)

12-Step Group Religious Group Family Friends Neighbors Support Group Counseling

ABOUT YOUR FAITH

Do you have any spiritual/religious background? Yes/No Are you currently involved, how much? ____________

Briefly explain your faith or belief: ____

____

ABOUT YOUR FAMILY OR SPOUSE
(If you have never been married, check here _____ and provide this information about your parents.)

Spouse/Family Names ____ Age ____________ Religion __________________________

Family or Spouse Occupation ____ Title ______________________________

Describe your Family or spouse's supportiveness of your counseling: (1 - no support, 10 - total support) ___________

May we contact your spouse/family about this counseling if needed? ____

Is your spouse/family willing to come for counseling if needed? ____

Date of this marriage _______________________________ Your ages when married: Husband ____________ Wife ___________

How long did you know your spouse before your relationship? ________ Length of dating? _____ Engagement? _____

Please rate your happiness in your family or marriage on a scale of -10 (unhappy) to +10 (perfectly happy) ________

Have you ever been separated? ______________ When? ______________________ How long? ___________________________

Has either of you ever filed for divorce? ____________ If yes, when? ______________ Was it granted? __________________

Number of *previous* marriages: How many? __________ Ended by death ___________Divorce _________________________

Briefly describe the reasons for *divorce:* ____

ABOUT YOUR CHILDREN

PM*	Child's Name	Gender	Current Age	Is Child Living?	Does Child Currently Live With You?

**Check this column if child is by a Previous Relationship.*

ABOUT YOUR PARENTS AND FAMILY HISTORY
If you were raised by anyone other than your own parents: ____

Answer this section describing your own parents (or parent substitute) when you were a child:

Father still living? Yes or No, Occupation ________________ Mother still living? Yes or No. Occupation _______________

Did or are your Parents Currently living together _________ If not, cause of separation? ______________________________

____

When did they separate?

____

How would you describe your parent's marriage? ____

As a child, did you feel closer to your father, your mother, or to someone else? ______________________________

How many brothers did you have? ______________________________ Sisters? ______________________________

What was your birth order? ____

ABOUT VIOLATIONS AND DECISIONS

Have you ever been abused? Verbally ______ Physically ______ Sexually ___________

Have you ever been an abuser? Verbally ______ Physically _____ Sexually _____________

Have you ever been involved with an abortion, how many? ______ Has your spouse, how many? _____________

Have you ever had an extramarital affair, how many? ___________ Has your spouse, how many? _____________

Identify traumatic events in your life (accident, bullying, death, assault, military, etc.): _____________________

____

ABOUT INSURANCE, WORK, AND SCHOOL

Type of work, school or level of education? ____

Do you have mental health benefits? _____ Insurance company ____

Have you contacted your insurance company? _____ Policy # _______________________ ID#: ______________

Yearly family income. Include all sources including medical assistance, family assistance, marital or partner income, pension, etc. required for sliding scale: $___________________

JUST ABOUT FINISHED

What is the main problem as you see it? Why are you here today?

____

With whom else have you discussed this issue? What steps have you already taken to resolve the problem?

____

What do you hope to accomplish by seeking counseling (your expectations)?

____

What do YOU expect to do in counseling?

____

How will you know when counseling is to be completed? What will need to occur?

____

Is there any information we should know that we didn't think to ask already?

____

FAMILY AND RELATIONSHIP HISTORY (Counselor will complete this section. Leave blank.)