**INSPIRING HEALING AND HOPE COUNSELING AND DEVELOPMENT CENTER, LLC**

**1899 Lake Rd suite 223, Hiram, GA 30141**

**404-907-6635**

**CLIENT INFORMATION**

1. **IDENTIFICATION**

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_-\_\_\_\_-\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_) \_\_\_\_\_\_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which numbers/email listed above may we leave a message on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is a minor: Names of Parent(s)/Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **RESPONSIBLE PARTY INFORMATION Check if the same as client (skip this section)**

Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **MEDICAL HISTORY**

Please list all Physician Names & Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any serious accidents, illnesses, operations or hospitalizations and what year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **FAMILY OF ORIGIN**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Relative** | **Name** | **Age** | **Illness** | **Education** | **Occupation** | **Quality of Relationship** |
| Father |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Step-Father |  |  |  |  |  |  |
| Step-Mother |  |  |  |  |  |  |
| Brother (s) |  |  |  |  |  |  |
| Sister (s) |  |  |  |  |  |  |

1. **Marital History**

Spouse’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Married: \_\_\_\_\_\_\_\_\_\_\_

Previous Married? \_\_\_ Yes \_\_\_\_ No Reason for Divorce: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Symptoms**

**Physical Health/Symptoms**

\_\_\_\_Headache \_\_\_Vomiting \_\_\_\_Diarrhea\_\_\_\_ Dizziness\_\_\_\_ Chest Pain\_\_\_\_ Shortness of Breath

**Function/Activity**

\_\_\_Fatigue \_\_\_Little/No Sleep \_\_\_ Weight Loss \_\_\_ Weight Gain \_\_\_ Loss of Interest Pleasure \_\_\_\_Excessive Worry \_\_\_Self-Injury \_\_\_\_Substance Abuse/Use \_\_\_\_\_\_Academic/Work Inhibition

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional Symptoms**

Hopelessness Panic/Anxiety Anger Tearful Suicidal Thoughts Indecisive \_Fearful Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply to you and may be a focus of treatment:

* Anxiety
* Depression
* Relationships and Boundary Issues
* Lying/Manipulation
* Academic Problems (Children and Adolescents)
* Behavioral Problems (Children and Adolescents)
* Marital Concerns
* Dealing with Divorce
* Parenting Concerns
* Risk of harming yourself or others
* Anger Issues
* Developmental Problems
* Sleep Problems
* Confidence/Self-Esteem Issues
* Feeling Isolated From Others
* Afraid or Suspicious
* Losing Track of Time
* Nightmares
* Intrusive Memories
* Sexual Issues
* Stress Management
* Traumatic Experiences
* Sexual Abuse
* Physical Abuse (Including Domestic Violence)
* Emotional/Mental Abuse
* Loss of Control
* Destructive Life Patterns
* Substance Abuse (Past and/or Present)
* Family of Origin Issues
* Career Changes
* Financial Problems
* Specific Fears or Panic
* Memory Problems
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about Inspiring Healing and Hope Counseling and Development Center?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?

Client or Legal Guardian Signature Date