Initial Counseling Form

Please complete this form and bring it with you to your first visit. Do not send it back via email.
All responses are welcome and will help me get a better sense of you and your needs more quickly so that we can make the best use of your time.

Name: _____ Preferred Name: _____ Date of Birth: ___/___/___

Please check the items below that are relevant to you seeking services at this time:

☐ Academic concerns	☐ Gambling concerns	☐ Relationship with friend/roommate
☐ Acculturation, adjustment to US culture	☐ Gender identity/expression	☐ Relationship with parents/children/family
☐ Alcohol/Drug use	☐ Grief/Loss	☐ Relationship with romantic partner/husband/wife
☐ Anger management	☐ Hearing/Seeing things others do not hear/see	☐ Self-esteem, self-confidence
☐ Anxiety, fear, worry	☐ Internet use/Gaming concerns	☐ Sexual assault or unwanted sexual experience
☐ Being assertive/Setting boundaries	☐ Legal concerns	☐ Sexual concerns
☐ Bias/Discrimination	☐ Loneliness/Isolation	☐ Sexual identity
☐ Body image concerns	☐ Physical/Sexual abuse	☐ Sleep problems
☐ Depression	☐ Physical stress (e.g., headaches, muscle tension)	☐ Social anxiety
☐ Disability	☐ Physical violence	☐ Spiritual/Religious concerns
☐ Eating concerns	☐ Pornography concerns	☐ Traumatic experience(s)
☐ Emotional/Verbal abuse	☐ Procrastination, motivation	☐ Other (please describe below):
☐ Employment concerns	☐ Racial identity	
☐ Financial concerns	☐ Relationship violence, stalking, and/or harassment	

How much are the concerns that you came to discuss currently disrupting your life? (please circle)

Not at all disruptive — Somewhat disruptive — Extremely disruptive

1 2 3 4 5 6 7 8 9 10

What motivates you to seek services at this time? _____

_____

Please list any current medical issues: _____

_____

Please list any currently prescribed medications with dosages: _____

_____

_____

Please list your prescribing providers: _____

_____

Please indicate if/when you have had the following experiences:	Never	Over a year ago	Within the last year	Within last 4 weeks
Attended counseling for mental health concerns	☐	☐	☐	☐
Taken a prescribed medication for mental health concerns	☐	☐	☐	☐
Purposely injured yourself without suicidal intent (e.g., cutting, burning, hitting)	☐	☐	☐	☐
Seriously considered attempting suicide	☐	☐	☐	☐
Made a suicide attempt	☐	☐	☐	☐
Considered causing serious bodily harm to another person	☐	☐	☐	☐
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror	☐	☐	☐	☐
Been hospitalized for mental health concerns	☐	☐	☐	☐

Think back over the last 2 weeks:	
How many times have you had 4 or more drinks in a row ("drink" = 12oz beer, glass of wine, or shot of liquor)?	How many times have you used marijuana?
☐ None ☐ Once ☐ Twice ☐ 3 to 5 times ☐ 6 to 9 times ☐ 10 or more times	☐ None ☐ Once ☐ Twice ☐ 3 to 5 times ☐ 6 to 9 times ☐ 10 or more times

Please check any other substances you have used:	**If checked, when was the last time you used the substance?**				
	Within the last week	Within the last month	Within last 6 months	Within the last year	Over a year ago
☐ Cocaine/Crack					
☐ Ecstasy					
☐ LSD					
☐ PCP					
☐ Heroin					
☐ Methamphetamine					
☐ Inhalants					
☐ Prescription drugs (non-medical use)					
☐ Other (specify):_____					

On average, how many caffeinated beverages do you consume on a daily basis? _____

On average, how many hours of sleep do you get on a typical night? _____

Typically, do you have difficulty falling asleep or staying asleep? _____

On average, how much exercise do you get each week? _____

Do you have health insurance?

☐ Yes
☐ No

If yes, do you plan to seek reimbursement from your insurance after paying in full for visits?

☐ Yes
☐ No