



Counseling and Wellness Center of South Florida

- ___ Staci Lee Schnell, M.S.,C.S., LMFT
- ___ Joele Amster, M.S.
- ___ Lexa Goldman, MA, LMHC, LMFT
- ___ Holly McIntyre, MSW, LCSW
- ___ Caela Cohen, M.S.Ed.
- ___ Katrina Lorenzo, M.S.
- ___ Jody Schultz, M.Ed, M.S.
- ___ Nyla Whitehead, M.S.
- ___ Dr. Alena Prikhidko, LMFT
- ___ Jordan Nodelman, MSW, LCSW
- ___ Alexandra Haves, MS, EdS
- ___ Dr. Nathalie Bello, LMFT
- ___ Jennifer Artesani Blanks, M.Ed., LMHC
- ___ Katalin Hanana, MS, LMHC
- ___ Ellen Rondino, M.S., LMFT
- ___ Marni Winters, M.S., LMHC
- ___ Dr. Liana Lorenzo- Echeverri, LMFT
- ___ Anna Schafer Edwards, M.S., MBA
- ___ Cassandra Cacace, M.S.
- ___ Sally Duerr Rodriguez, M.S., LMHC
- ___ Michelle Bennett, M.S.

Client Information

Welcome to the practice. To speed up the initial process if you would please fill out this form as completely as you can, we will use this to get started quickly. All information you provide will be kept confidential within the guidelines expressed in the Client Handbook. Thank you.

Please Print

Name: _____ Date: _____ FILE # _____

Address: _____

(City) _____ State: _____ Zip: _____

	OK to Contact		OK to send/leave message	
Email Address: _____	Y	N	Y	N
Home Telephone: _____	Y	N	Y	N
Work Telephone: _____	Y	N	Y	N
Cell Phone: _____	Y	N	Y	N

Age: ___ Date of Birth: ___/___/___ Gender _____

Place of Birth: _____ How long have you lived in Florida? _____

Military Service: Branch: _____ From _____ To _____

Education: _____

Employment Status: _____

Primary Insurance: _____ Insurance Id: _____

Secondary Insurance: _____ Insurance Id: : _____

Social Security #: _____

Describe your primary reason for coming to counseling: _____

Whom may I thank for referring you?

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I give my permission to send a letter of acknowledgment to my referral source:

(Your Signature)

Emergency Contact Name & Number: _____

Please Sign _____

Family Information

Current Marital Status:

Married: _ Divorced: _ Separated: _ Widowed: _ Co-Habiting: _
Single: _ Engaged: _ Other _____

List all of your household members:

Name	Age	Relationship	Occupation/(School/Grade)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Please list all of your marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please list all of your Spouse's marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Medical and Psychotherapy History

Any Surgeries? Yes No

Procedure	Date	Comments/Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any current medical diagnosis or diseases? Yes No

Diagnosis	Date	Comments/Status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any current treatments or therapies for these conditions? Yes No

Family Impact of Diagnosis:

Any previous psychotherapy? Yes No

Date Started	Date Completed	Purpose of Therapy	Therapist
_____	_____	_____	_____

How helpful was it? Much improved Somewhat improved Improved
Worse Somewhat worse Much worse No change

Any hospitalizations? Yes No

Date	Hospital	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications:

Medication	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

May I contact physician(s) to co-ordinate treatment? Yes No

Signature _____

Clinical Information

Name: _____

Signature: _____

Please check all items that you have experienced in the last 6 months:

Physical Symptoms

- Headaches
- Fainting Spells/ Dizziness
- No appetite/Overeating
- Stomach/ Bowel disturbances
- Palpitations
- Tremors – shaking
- Difficulty sleeping
- Increased Confusion
- Decreased mobility
- Fall Risk
- Tired/No Energy

Emotional Symptoms

- Anxious
- Depressed
- Relationship Issues
- Excessive Fears/Worries
- Inferiority feelings
- Panic Attacks
- Anger Issues
- Feeling Tense/Stressed
- Grief/Loss
- Poor Decision Making
- Loss of Interest in Activities
- Exhausted coping skills

Other _____

Social/Family Issues

- Marital/Partner problems
- Financial Problems
- Life transitions
- Change in living environment
- Adjustment problems
- Loss of Independence
- End of Life Planning

Addictions

- Drinking Problem
- Drug Abuse
- Gambling Addiction
- Sexual Addiction
- Food Addiction
- Excessive Shopping

Mental Health

- Previous Suicide Attempts
- Suicidal Ideation
- Visual/Auditory Hallucinations
- Negativistic thinking
- Disturbing thoughts or fears
- Manic

Please describe in detail those items checked above and for how long you have been experiencing each:
