Counseling and Wellness Center of South Florida

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# 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:_________________________

Seconary 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-Habitating:_
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 <u>your</u> 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 <u>Spouse's</u> 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:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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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

**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

□ Other______________________________________________________________

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

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________