Client Information

Date: ___________________________

Full Name: ____ Gender: ________ Age: ________

Address: ____ Date of Birth: ____________________

____ SS # ___________________________

Phone(s): (H)____ May we leave a message? Yes No

(C)____ May we leave a message? Yes No

Email: ____ May we email you? Yes No

Preferred Email for reminders of scheduled appointments (if different): ______________________________

Note: Phone and/or Email correspondence is not considered to be a confidential medium of communication for clinical discussions.

Marital Status: Single Engaged Married Separated Divorced Domestic Partnership Widowed

Employer/School: ____________________________________ Occupation: ____________________

Education: ____ Yearly Income (optional): __________

Are you currently in the Armed Forces? Yes No Veteran: Yes No

Emergency Contact:

Name: ______________________________ Phone: __________________ Relationship: ______________

Insurance Name: ________________________ Member No: ________________ Group No: ________________

Secondary Insurance: ____________________ Member No: ________________ Group No: ________________

Primary Physician: ___________________________________ Last Examined by a Doctor: ______________

Do you have any physical disabilities or limitations? Yes No

If yes, please explain: ____

Reason for Visit: Provide a brief history of the issues for which you are seeking assistance.

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What is your desired outcome from therapy?

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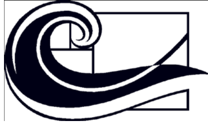

HARMONY HARBOR COUNSELING
Mindful Care for Balanced Living

Any Previous Therapy: Yes No If yes, with whom? ______________________________

Reason? ______________________________

Helpful: Yes No Some Comments: ______________________________

____

Previous psychiatric hospitalization? Yes No

If yes, number of hospitalizations: __________ When? ______________________________

Family History of Psychiatric/Emotional/Behavioral/Substance Abuse problems: ______________________________

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List any major health problems currently being treated: ______________________________

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List any significant medical or substance abuse problems that you have previously experienced: __________

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____

Medications:

List Current: ______________________________

____

____

List Past (include past psychiatric medications): ______________________________

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Do you consider yourself to be spiritual? Yes No Describe (if any): ______________________________

Do you consider yourself to be religious? Yes No Affiliation (if any): ______________________________

Describe your current faith or current spiritual/religious concerns (if any): ______________________________

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Any other important information that you want us to know: ______________________________

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support@harmony-harbor.com

Please check all items below that apply to your current concerns:

	Academic concerns		Emotional or psychological abuse		Obsessive thoughts
	Addiction concerns		Family concerns		Panic attacks
	ADHD/ADD		Fears of abandonment/rejection		Paranoia
	Aggressive behavior		Feeling that you/things around you are not real		Phobias
	Ageing parents		Feelings of emptiness		Physical abuse or assault
	Alcohol blackouts		Financial concerns		Procrastination
	Anger/frustration management		Flashbacks (not drug related)		Self-control
	Anxiety, fear, nervousness		Gambling		Self-esteem
	Appetite disturbance		Guilt		Self-harm thoughts/actions
	Burnout		Harassment		Separation/marital concerns
	Career/job		Hopelessness		Sexual abuse or assault
	Children/parenting		Homicidal thoughts		Sexual function
	Chronic pain		Impulse control		Sexuality concerns
	Codependency		Internet/videogame addiction		Shyness
	Compulsive behavior		Intimate relationship concerns		Single Parent
	Concentration difficulties		Isolation/social withdrawal		Sleep difficulties
	Concern with other's well-being		Learning concerns		Social concerns
	Cutting or self-injury		Legal concerns		Spiritual or religious concerns
	Delusions/hallucinations		Low energy/fatigue		Stress or tension
	Depression, sadness		Loneliness		Suicidal thoughts/actions
	Difficulty trusting others		Manic behavior		Thoughts racing/can't hold onto an idea
	Divorce		Medical or health concerns		Transition difficulties
	Domestic violence concerns		Memory problems		Trouble making decisions
	Drugs		Mood swings		Unemployment
	Eating concern (binge, purge, obesity)		Nightmares		Weight loss or gain

Are there any other problems or symptoms? ______________________________

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