HARMONY HARBOR
COUNSELING
Mindful Care for Balanced Living

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.

_____

_____

_____

_____

What is your desired outcome from therapy?

_____

_____

_____

2201 Cantu Ct, Suite 104
Sarasota, FL 34232

Office: 941-867-0047
Fax: 941-806-0447

www.harmony-harbor.com
support@harmony-harbor.com

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: _____

_____

_____

List any major health problems currently being treated: _____

_____

_____

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

_____

_____

Medications:

List Current: _____

_____

_____

List Past (include past psychiatric medications): _____

_____

_____

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): _____

_____

_____

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

_____

_____

_____

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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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