ANEW FAMILY COUNSELING CENTER

Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating

Current partner's name:	**Partner's Occupation:**	**Length of Relationship:**

How satisfied are you with your current relationship (on a scale from 1-10)?

(very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)

Are you currently experiencing any depression? YES/NO	**Are you experiencing anxiety? YES/NO**
Scale level of depression (0-10) 10 being the highest: 1 2 3 4 5 6 7 8 9 10 (circle one)	**Scale level of anxiety (0-10) 10 being the highest: 1 2 3 4 5 6 7 8 9 10 (circle one)**

Highest level of education:	Highschool	Some college	College degree	Graduate School	Other

If you received a college/graduate degree, what was your degree in?

If you are currently a student, what are you studying?

How would you describe your spiritual or religious beliefs?

Have you ever been abused or abusive: YES/NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other

Do you have a primary care physician? YES/NO	**Physicians name:**

Are you under the care of a specialist? YES/NO

If yes, please circle type of specialist:

Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability/Diagnosis	Dates

Client Initials: _____

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List all medications you are currently taking:

Medication	**Dosage**	**Treating**
Are you taking the medications according to your doctor's recommendation? YES/NO If No, briefly explain:		

Average number of hours you sleep at night?	**How long does it take for you to fall asleep?** ____min.____hrs.

Do you drink alcoholic beverages? YES/NO	**If yes how many alcoholic beverages do you drink?** _____weekly_____ daily
Do you think you have a drinking problem? YES/NO	**Does anyone else think you have a drinking problem?** YES/NO
Have you in the past or currently: used, abused, or experimented with illegal drugs? YES/NO	**If yes, briefly explain:**
Have you ever attempted/seriously contemplated suicide? YES/NO	**Do you have any thoughts about harming others?** YES/NO

Have you ever had a psychiatric hospitalization? YES/NO
If yes, describe briefly and indicate dates:

Are you currently seeing another therapist? YES/NO
If yes, please indicate the therapist's name:
Have you ever been in therapy in the past? YES/NO

Client Initials: _____

If yes, please fill out the following on your previous counseling experience(s):

Therapist	Location	Dates	Reason for therapy

Briefly describe your reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

Is there anything else you would think would be important for me to know about you and your family?

How were you referred to our office?

Client Initials: _____