



Counseling and Wellness Center of South Florida

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- \_\_\_ Ellen Rondino, 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 expresses 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: \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_

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

Military Service: Branch: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Education: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_

Address: \_\_\_\_\_

(City): \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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
- Poor sleep
- Nightmares/ Night Tremors
- Unusual bodily sensations
- Sexual Problems
- Tired/No Energy

## Emotional Symptoms

- Anxious
- Depressed
- Self-Esteem Issues
- Fears/Worries
- Inferiority feelings
- Panic Attacks
- Anger Issues
- Feeling Tense/Stressed
- Shy
- Poor Decision Making
- Lack Ambition or Interests
- Unable to relax

- Other \_\_\_\_\_

## Social/Family Issues

- Marital/Partner problems
- Parent/Child problems
- Unemployed/Work Issues
- Financial Problems
- Court/Legal problems
- Problems making/keeping friends

## Addictions

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

## Mental Health

- Previous Suicide Attempts
- Suicidal Ideas
- Visual Hallucinations
- Hearing Voices
- Disturbing thoughts or fears
- Manic

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

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