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:___/___/___ Male_ Female_
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 □

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____

____

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
- □ 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:

____
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____
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