CWCSF

Counseling and Wellness Center of South Florida

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Family Information

Welcome to the practice. To speed up the initial process if you would please fill out this form as completely as possible, we will be able to get started quickly. All information provided will be kept confidential within the guidelines expresses in the Client Handbook. Thank you.

Please Print

Spouse/Partner #1 Name:_____ Date:_____ FILE #_____
Address:_____
(City)_____ State:_____ Zip:_____
Age:___ Date of Birth:___/___/___ Male_ Female_

	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

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:_____
_____
_____
_____

Please Sign_____

Spouse/Partner #2 Name:_____
Address:_____
(City)_____ State:_____ Zip:_____
Age:___ Date of Birth:___/___/___ Male_ Female_

	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

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:_____
_____
_____
_____

Please Sign_____

Whom may I thank for referring you?
Name:_____Address:_____
City:_____State:_____Zip:_____Phone:_____
We give our permission to send a letter of acknowledgment to our referral source:
_____
(Signatures)

Family Information

Current Marital Status:

Engaged: _ Married: _ Divorced:_ Separated:_ Co-Habitating:_
Single: _ Widowed:_ Other:_____

List all household members:

Name	Age	Relationship	Occupation/(School/Grade)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____

Spouse #1 List all of <u>your</u> marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Spouse #2 List all of <u>your</u> marriages or significant relationships including this one.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Spouse/Partner #1 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:_____

Spouse/Partner #2 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: _____

Child #__ Medical and Psychotherapy History

Parents please fill out:

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 □

Parent Signature_____

Spouse/Partner #1 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

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

□ Other_____

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

_____
_____
_____
_____
_____
_____

Spouse/Partner #2 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:

_____
_____
_____
_____
_____

Parents please fill out:
Child Name: _____ Parent Signature: _____

Please check all items that **your child** has 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

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

□ Other_____

Please describe in detail those items checked above and for how long your child has been experiencing each:

_____
_____
_____
_____
_____

Clinical Information

To be filled out by Child/Adolescent if able:
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

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

□ Other_____

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

_____
_____
_____
_____
_____