Name: _____ Today's Date: ____/____/_____
Preferred phone # for reaching you: (____)_____

5. HEALTH INFORMATION (please check one): ☐ Excellent ☐ Very Good ☐ Average ☐ Poor

Medications, Purpose and Person Prescribing

Medical Conditions	Allergies	Medications	Purpose	Who prescribed?

Are you currently experiencing any physical pain? NO YES If yes, where and for how long?

Do you get headaches? NO YES If yes, where and for how long?

Do you have difficulty sleeping? NO YES If yes, how often each week and time it takes?

My current use of the following substances:

Item	Quantity/How much?	Frequency/How often?
Caffeine		
Alcohol		
Nicotine		
Illegal drugs		

Are you abusing or addicted to any substance or behavior (or have been in the past)?

Do you feel like hurting or killing yourself or others? NO YES If yes, who & how?

Have you been abused (mentally, physically or sexually) **or traumatized? NO YES**
If Yes, please explain

6. REASONS FOR SEEKING COUNSELING:
My reasons for seeking counseling or therapy are . . .

What I've done to attempt to solve the problem ...

What I hope to see happen as a result of coming here...

What I expect from my counselor / therapist is .....

Signature _____ **Date** _____