Stiles Counseling Services LLC

Client Information

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY.
IF COMING AS A COUPLE, EACH PERSON NEEDS TO FILL OUT HIS/HER OWN FORM.

First Name ________________________________ MI ____ Last Name ____________________________

Address ___________________________ City ___________________ State _______ Zip _____________

Telephone (Home) __________________________ (Cell) _____________________________

May we call you at home? Y N May we leave a message at home? Y N
May we call your cell? Y N May we leave a message on your cell? Y N

Birthdate __________________ Age _________ Social Security Number ___________________________

Gender ___ F ___ M Race _______________________ County of Residence _______________________

Marital Status ___ single ___ married ___ divorced ___ widowed ___ other _________________

Name of Spouse/Partner ______________________ Phone __________________________
Length of marriage/relationship: ______________________ Number of marriages: ______________

Children ___ Y ___ N If yes, how many? _____ Living at home? ______________ Step-Children? _______

Gender & Ages ____

EDUCATION: Check the box that applies to you.

□ Some High School □ High School Grad □ High School GED □ Techincal/Trade
□ Some College □ College Grad □ Post-Graduate Work □ Post-Graduate Degree

Profession: _________________________________ Employer: ________________________________

In case of emergency, I give my permission to contact:

Name ____ Relationship _____________________________

Telephone (Home) _____________________ (Work) ___________________ (Cell) ___________________

Referral Source:
How did you hear of our office (or from whom)? ____

E- Mail Address ____ Add to e-newsletter list? ____Y ____ N

Ok to email regarding appointment dates/times and billing/insurance? ____Y ____ N

Would you like to receive an *appointment reminder* via email? ____Y ____ N

If yes, print email address *clearly*! Also, note that there is no guarantee of a reminder and it is still your responsibility to keep your appointment time or notify us at least 24 hours in advance to avoid a charge.

Client Signature ______________________________________ Date _____________

Name:________________________________

Physician ____ Phone ___________________________

Address ___________________________ City ____________________ State _______ Zip ____________

Date of last medical exam? ____________________________

Psychiatrist ____ Phone ___________________________

Address ___________________________ City ____________________ State _______ Zip ____________

PERSONAL CONCERNS: (Please check if concerns apply, if not leave blank).

Past	Present		Past	Present	
		Thoughts about hurting yourself			Thoughts about hurting others
		Thoughts of ending your life			Anger
		Suicide attempt(s) &/or self-harm			Anxiety/Excessive worry
		Flashbacks or nightmares			Panic attacks
		Physical or Sexual Abuse			Difficulty in concentrating
		Verbal/Emotional Abuse			Racing thoughts
		Excessive sadness or hopelessness			Paranoia
		Legal issues (DUI, bankruptcy, arrestes, etc.)			Hallucinations (seeing/hearing things others don't)
		Gambling Problem			Blackouts (periods of time you don't remember)
		Compulsive Spending/Shopping			Eating Disorders/Body Image Concerns
		Shoplifting/Theft			Marital/Relationship Concerns
		Obsessions/Compulsions			Sexual Difficulties
		Hoarding (excessive accumulation of items)			Pornography
		Alcohol Problem			Parenting/Child Concerns
		Drug Problem			Career Issues/Difficulties at work
		Grief/Loss			Self-Esteem Issues

What concerns or issues convinced you to seek assistance now? ______________________________________

____

____

How long have these been a concern? ____

What are your goals for therapy? ____

____

____

Do you feel comfortable discussing difficulties with family or friends? __________________________

Who do you turn to for emotional support or help with your problems?__________________________

Are your religious or spiritual beliefs a source of support? _________________________________

Is there a history of mental health problems in your family? Yes ☐ No ☐ ______________________

Is there a history of substance abuse in your family? Yes ☐ No ☐ ______________________

Current or pending legal issues? Yes ☐ No ☐ ______________________

Please rate the following (based on past month):

Anxiety/Worry	_____ Extremely high	_____ High	____ Moderate	____ Low	____ None
Depression	_____ Extremely high	_____ High	____ Moderate	____ Low	____ None
Stress Level	_____ Extremely high	_____ High	____ Moderate	____ Low	____ None

Name: ______________________________

Have you ever used?

	Never	Yes, Earlier in Life	Yes, within the last months	Frequency and Amount
Tobacco				
Alcohol				
Street Drugs				
Caffine				

PREVIOUS COUNSELING:

Have you had previous counseling or are you currently in treatment with any other mental health provider?

Yes ☐ No ☐ Current provider(s): ____

Past provider(s): ____

____

Please list *all* current medications and/or supplements (add on back or bring list if needed).

Medication Dosage Method (oral, topical etc.)

____

____

____

____

What medications have you taken in the past for your emotional/mental well being? ____________________

____

PHYSICAL HEALTH:

How is your physical health? ________Good _________Fair ________ Poor

Please mark all Past and/or Present conditions or concerns. Leave blank if not applicable.

Past	Present		Specify	Any Medications Prescribed?
		Allergies		
		Adverse reactions to medications		
		Digestive problems/gastrointestinal		
		Weight gain/loss		
		Appetite Loss		
		Heart		
		High / Low Blood Pressure		
		Thyroid		
		Lungs/respiratory/breathing		
		Diabetes		
		Sleep difficulties _________________		
		Seizures		
		Head injury		
		Auto Immune disorders		
		Other _________________________		

Any other health issues or concerns? ____

Overall, how is your life going compared to a year ago? ____ Better ____ About the same ____ Worse