PLUM CREEK COUNSELING

1505 S. Main St., Suite 1004, Lockhart, Tx., 78644 (512) 398 7586

General Information

Full Name: _____Name You Prefer:_____

Date:_____Age:_____Date of Birth:_____

Street Address:_____Suite/Apartment Number:_____

City:_____State:_____Zip Code:_____May I Send Mail Here: □ Yes □ No

Home Phone: (____) _____ May I Leave a Message Here? □ Yes □ No

Cell Phone: (____) _____ May I Leave a Message Here? □ Yes □ No

Work Phone (____) _____ May I Leave a Message Here? □ Yes □ No

Email Address _____ May I Send Email Here? □ Yes □ No

Emergency Contact Name _____ Relationship: _____

Home Phone (____)_____ Cell Phone (____)_____

Referral

How did you hear about me? _____
May I contact this person to thank them? □ Yes □ No

If you agree to let me thank them, sign here:_____ Date:_____

Referral's Phone Number: (____) _____ Referral's Email:_____

Employment and Education:

Employer:_____Length of Employment:_____

Occupation:_____Average Hours per week:_____

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College □ 1 □ 2 □ 3 □ 4 □ Other: _____

Are you currently in school? □ Yes □ No If Yes, what level: _____ Degree Pursuing:_____

Relational Information:

Current Relational Status: □ Single □ Dating □ Engaged □ Partner □ Married □ Separated □ Divorced □ Widowed

Are you content with your current status? □ Yes □ No If No, briefly explain: _____

_____

If married, partner, separated, divorced, or widowed, how long? _____

Number of previous marriages for you? _____

If in relationship, current partner's name:_____ Age:_____

Partner's Occupation:_____ Average Hours Worked per Week:_____

What words would you use to describe your partner?_____

_____

Is your partner supportive of you seeking counseling? □ Yes □ No □ Unsure □ Partner doesn't know

With whom do you currently live (check all that apply) □ Alone □ Spouse □ Children □ Parents

□ Siblings □ Boyfriend □ Girlfriend □ Roommate(s) □ Other:_____

Children:

List Your Children (Living or Deceased)

1st Name_____ Sex_____ Current Age or Year of Death_____

Relationship to You (e.g. Natural, Adopted, Step)_____Living with you_____

Describe Them_____

2nd Name_____ Sex_____ Current Age or Year of Death_____

Relationship to You (e.g. Natural, Adopted, Step)_____Living with you_____

Describe Them_____

3rd Name_____ Sex_____ Current Age or Year of Death_____

Relationship to You (e.g. Natural, Adopted, Step)_____Living with you_____

Describe Them_____

Family of Origin

List Mother, Father, Brothers, Sisters, Step Father, and any other family members who affected you positively or negatively:

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling, Step, etc)	Occupation	Describe him/her

Medical Information:

Primary Physician:_____ Phone: (____) _____

Are you currently receiving medical treatment? □ Yes □ No If Yes, please specify: _____
_____

Medications:

List any current medications you are taking (use back if necessary):

Medication:_____ Purpose:_____

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Are you taking these medications according to your doctor's recommendations? □ Yes □ No

If No, briefly explain: _____

Level of distress:

Indicate how distressed you are by circling the number below, 1 = very little distress, 10 = extreme distress:

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No If Yes, when and how? _____

_____

Have any of your friends or family ever committed or attempted suicide? □ Yes □ No If Yes, when and who? _____

Religious Background

What are your current spiritual beliefs?

_____

_____

Do you have a personal support system? □ Yes □ No If Yes, who? _____

What words would you use to describe yourself: _____

_____

Previous Counseling:

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back if necessary):

Therapist:_____Location:_____Dates:_____

Reason:_____

Therapist:_____Location:_____Dates:_____

Reason:_____

Presenting Issues and Goals

Please describe why you are coming to counseling (i.e. What are your issues, problems?): _____

_____

_____

_____

Why have you decided to come for counseling now?_____

_____

_____

What do you hope to gain or change by coming for counseling?_____

_____

_____

How long do you believe counseling should last?_____

_____

Terms of Service

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24 hour notice of intention to cancel, I will be charged the full appointment fee for service.

_____ _____

Client Signature(parent or guardian of minor) Date