Real Life Counseling, LLC

Real People Helping Others Experience The Real Life

COUNSELING INFORMATION

(ALL INFORMATION IS PRIVATE & CONFIDENTIAL)

I - General Information

Name: _____ Date: _____

Birth Date: _____ Age: _____

If Under 18, Please give Parent's or Guardian's Name: _____

Current Address: _____

Street

_____

City State Zip

Home Phone: _____ Work: _____

Cell/Beeper: _____ Best #: _____

Employer: _____ How long at Present Job? _____

Marital Status: _____ Spouse's Name: _____ Spouse's Age: _____

Years Married: _____ Spouse's Occupation: _____

Previous Marriages: Yes____ No____ If Yes, How many times have you been Married? _____

Children's Names	Age	Sex	Relation	At Home	School Grade

Who Referred you to this Office? _____

II - Medical Concerns

Family Physician: _____ Date of Last Physical: _____

Address: _____
Street

_____
City State Zip

Phone Number: _____ Fax: _____

Please List All Current Prescribed Medications:

_____

_____

Please List All Vitamins, Herbals, Homeopathic or Over the Counter Medicines that you take Regularly:

_____

_____

_____

Pleas List All Major or Chronic Illnesses: _____

_____

Hospitalizations (Medical &/or Psychiatric): _____

_____

Current Medical Problems & Symptoms: _____

_____

Family Members who have had Medical/Psychological Problems: _____

_____

III - Counseling Concerns

Previous Counseling: Yes____ No____ Type of Counseling:_____

Reason for Past Counseling & for How Long? _____

_____

_____

Briefly Describe your Reasons for Seeking Counseling at this Time: _____

_____

_____

Please Indicate the Severity of your Problems on the Scale Below:

Mild_____ Moderate_____ Severe_____ Extremely Severe_____ Incapacitating_____

Describe Significant Events Surrounding or Leading up to the Problem:_____

What Solutions have you Tried or Considered Trying?

Please Circle Any of the Following that Applied to you as you were Growing up:

Happy Childhood	School Problems	Medical Problems	Sexual Abuse
Unhappy Childhood	Family Problems	Substance Abuse	Physical Abuse
Emotional Problems	Behavioral Problems	Legal Problems	Identity Problems

Others Not Listed Above: _____

Please Describe: _____

Do you have Strong Religious Convictions: Yes____ No____ If Yes, What is your Faith Tradition:

Have you Ever Thought about Suicide? Yes____ No____

Have you Ever Attempted Suicide? Yes____ No____ If Yes, When & How?

Counselee: Date: