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**Personal Information**

Name (Primary Client in Family):			Home Phone:	Cell Phone	Cell Carrier	Email Address:	
Address:			Alternate phone	SSN	Medicaid	Annual Household Income	
Address Cont'd			DOB	Gender M      F	Ethnicity	Education	Employment
City	State	Zip Code	In Case of Emergency Contact			Emergency Contact phone number	

**Financial Information**

Responsible Financial Party			Insurance Company	Insurance Company Address		
Address:			Insurance Company phone	Insured DOB	Insured Gender M      F	Insured SSN
City	State	Zip Code	Insurance ID Number	Group Number	Effective Date	

**Household (Family) Members**

Name	Age	Occupation/Grade in School	Relationship to Primary Client

**Medical Information**

Physician – Medicine Prescriber	Emergency Contact:	Medications:	Dosage	Frequency
Who referred you?	Emergency Contact Phone:	Name		
Reason For Counseling				
Goals for Counseling				
1.				
2.				
3.				
4.				

**Symptoms**

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Low energy	<input type="checkbox"/> Weight	<input type="checkbox"/> Suicidal	<input type="checkbox"/> Sleep/Insomnia	<input type="checkbox"/> Shy	<input type="checkbox"/> Memory
<input type="checkbox"/> Panic	<input type="checkbox"/> Crying Spells	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Mood Swings.	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Concentration	<input type="checkbox"/> Suspicious	<input type="checkbox"/> Stress
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Irritability	<input type="checkbox"/> Grief/Mourn	<input type="checkbox"/> Anger	<input type="checkbox"/> Motivation	<input type="checkbox"/> Legal	<input type="checkbox"/> Drug Use	<input type="checkbox"/> School
<input type="checkbox"/> Specific Fears	<input type="checkbox"/> Low Energy	<input type="checkbox"/> Disappointed	<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Money	<input type="checkbox"/> Compulsions	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Worry	<input type="checkbox"/> Appetite	<input type="checkbox"/> Sexual problems	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Physical Illness	<input type="checkbox"/> Work	<input type="checkbox"/> Drinking	<input type="checkbox"/> Rejection
<input type="checkbox"/> Aggression	<input type="checkbox"/> Running Away	<input type="checkbox"/> Violence	<input type="checkbox"/> Attachment	<input type="checkbox"/> Indecision	<input type="checkbox"/> Marital Conflict	<input type="checkbox"/> Irrational	<input type="checkbox"/> Confusion
<input type="checkbox"/> Voices	<input type="checkbox"/> Parenting	<input type="checkbox"/> Memory	<input type="checkbox"/> Stress	<input type="checkbox"/> School	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Rejection	<input type="checkbox"/>