DeYoung Consulting
Safe, Stable, Successful Families.

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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	Ethnicity	Education None	Employment None
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	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: Name	Dosage	Frequency
Who referred you?	Emergency Contact Phone:			
Reason For Counseling				
Goals for Counseling 1. 2. 3. 4.				

Symptoms

☐ Anxiety	☐ Depression	☐ Autism/Asperg.	☐ Weight	☐ Suicidal	☐ Sleep/Insomnia	☐ Shy	☐ Sexual Addict
☐ Panic	☐ Crying Spells	☐ Loneliness	☐ Mood Swings.	☐ Sensitive	☐ Concentration	☐ Suspicious	☐ Reactive Attach
☐ Restlessness	☐ Irritability	☐ Grief/Mourn	☐ Anger	☐ Motivation	☐ Legal	☐ Drug Use	☐ Compulsions
☐ Specific Fears	☐ Low Energy	☐ Disappointed	☐ Perfectionism	☐ Impulsive	☐ Money	☐ Drinking	☐ Withdrawal
☐ Worry	☐ Appetite	☐ Sexual problems	☐ Hopeless	☐ Physical Illness	☐ Work	☐ Irrational	☐ Rejection
☐ Aggression	☐ Running Away	☐ Violence	☐ Attachment	☐ Indecision	☐ Marital Conflict	☐ Rejection	☐ Confusion
☐ Voices	☐ Parenting	☐ Memory	☐ Stress	☐ School	☐ Withdrawal	☐ Personality Dis.	☐ Marital Affairs