VIRGINIA COUNSELING ASSOCIATES

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Personal Information

Client Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age:

_____

Address: _____
(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Mental and Physical Health Treatment & History

Have you **previously received any type of mental health services** (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Have you ever been hospitalized for psychological/emotional difficulties?

□ No

□ Yes If yes, explain difficulty, dates hospitalized & type of medication

_____

_____

Are you **currently taking any prescription** medication?
□ Yes
□ No
Please list: _____

_____

Have you ever been prescribed or are you currently taking psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____

_____

How would you rate your **current physical health**? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your **current sleeping habits**? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns

_____

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

Have you had **suicidal thoughts** recently? ___frequently ___sometimes
___rarely ___never
Have you had them in the past? ___frequently ___sometimes
___rarely ___never

Have you ever intentionally inflicted any harm upon yourself? ___Yes ___No
___Unsure

Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

What significant life changes or stressful events have you experienced recently?

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

_____

Problem Description Duration

Briefly **describe the problem** you most wish help with right now:

_____

_____

_____

How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number):

1 2 3 4 5 6
Not intense Moderately Intense Extremely Intense

Approximately **how long** have you had the current problem?

_____

In what ways have you **attempted to cope** with this problem?

_____

_____

_____

Family & Personal Background

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____

1. On a scale of 1-10, how would you rate your relationship? _____
2. Have you been **married/partnered before**? Yes No If yes, when and for how long?

   _____
3. Please list the names of your **children** or dependants.

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Please check any past, present, or impending **special problems in your family**:

___deaths ___divorce ___frequent relocations
___serious illness ___debilitating injuries/disabilities
___alcohol/drug abuse
___psychiatric disorder ___physical/sexual abuse ___legal problems
___financial crisis/unemployment
___attempted/completed suicide ___eating disorders
___other _____

Please specify **family member(s), with special problems**, and approximate year of occurrence (e.g. mother, serious illness, 1998, etc.)

_____

_____

_____

Would you like **anyone else** involved in the counseling with you? (family members, friends, etc.)

_____

_____

Is there a concern about **violence** in your life today? Either from you or towards you? Please explain:

_____

_____

How concerned are you on a scale of 1 to 10, with 10 being the worst ? (Circle one):

1 2 3 4 5 6 7 8 9 10

Have you personally experienced significant **family abuse**?

___none ___unsure ___emotional ___physical
___sexual

Have you personally experienced **legal problems**? ___NO ___YES

Did you experience **learning problems** in elementary or high school? (Check one):

___none ___little ___some ___substantial
___lots, constant struggle

In general, how **happy or adjusted** were you growing up? (Check one):

___poor ___unsatisfactory ___about average ___substantial ___completely

Relationships

How much is your immediate family a source of **emotional support** for you? (Check one):

__none ___little ___somewhat ___substantial ___very strong

How much **conflict in values** do you currently experience with your parents? (Check one):

___very little or none ___some ___moderate ___strong ___extreme

Who in your family do you currently **feel closest** to?

_____

Most **distant** from? _____

In most **conflict** with?_____

If you are married or in a committed relationship, are you currently **in the process of separation or divorce**? Please specify:

_____

What is the length of time apart?

_____

IF yes, what reason(s) have you given your children for the current problem?

_____

_____

How committed are you to making your marriage/relationship work?

_____

_____

What changes are you willing to make for the sake of your marriage/relationship?

_____

_____

_____

Describe any concerns regarding **sexual or emotional intimacy** with your spouse/partner.

_____

_____

_____

Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?

___frequently ___a few times ___once ___never ___unsure

In the past, how would you rate the quality of your **peer relationships**?

___very poor ___unsatisfactory ___about average ___good ___excellent

Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in?

_____ Are you in one now? ___Yes ___No ___I think so

Besides family members, approximately how many people can you really count on right now for friendship or **emotional support**? _____

ABOUT YOUR CONCERNS

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Please check all the items below that you currently experience or having difficulty, and feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

	Abortion		Grieving, mourning		Physical problems
	Abuse - emotional		Guilt		PMS
	Abuse - neglect		Headaches, pains		Poor self-care
	Abuse - sexual		Health, illness		Pornography use
	Adoption		Hearing voices		Procrastination
	Aggression		Hostility		Relationship problems
	Alcohol Use		Hyperactivity		Relaxation
	Ambition		Impulsive spending		Re-marriage
	Anger		Impulsiveness		Risk-taking
	Anxiety		Incest		Sadness
	Arguing		Indecision		School problems
	Attention problems		Inferiority feelings		Self abuse - burning
	Career concerns		Infertility		Self abuse - cutting
	Childhood issues		Inhibitions		Self abuse - other
	Children – care of		Interpersonal conflicts		Self abuse - scratching
	Children - custody		Irresponsibility		Self abuse – pulling hair out
	Children - management		Irritability		Self-centeredness
	Choices I've made		Judgment problems		Self-control
	Chronic pain		Laziness		Self-esteem
	Codependence		Legal matters, charges, suits		Self-neglect, poor self-care
	Communication		Loneliness		Separation
	Compulsive spending		Loss of control		Sexual addiction
	Confusion		Losses		Sexual conflicts
	Constant conflicts		Loss of interest in activities		Sexual desire differences
	Crying		Loss of interest in sex		Shyness
	Deaths		Low energy		Smoking
	Debt		Low frustration tolerance		Spirituality
	Decision making		Low income		Step-parenting
	Dependence		Low mood		Stress
	Depression		Marital conflict		Stress-management
	Distractibility		Marital distance		Suspiciousness
	Divorce, separation		Marital infidelity/affairs		Temper problems

	Domestic violence		Medical concerns		Tension / stress
	Drug abuse – over the counter		Memory problems		Thought disorganization
	Drug abuse - prescription		Menopause		Threats of violence
	Drug abuse – street drugs		Menstrual problems		Tiredness
	Drug abuse - alcohol		Mixed feelings		Tobacco use
	Education		Mood swings		Unhappiness
	Employment – lack of		Motivation		Violence
	Employment - overdoing		Mourning		Violence – victim of crime
	Employment problems		Nail-biting		Weight and diet issues
	Employment - termination		Nervousness		Withdrawal - isolating
	Emptiness		Nightmares		Work problems
	Exhaustion		Obsessions, compulsions		Worry all the time
	Failure		Outbursts		**Other concerns or issues:**
	Fatigue, low energy		Oversensitive to criticism		
	Fears, phobia		Oversensitive to rejection		
	Feelings of helplessness/hopeless		Overweight		
	Financial troubles		Panic or anxiety attacks		
	Friendship problems		Parenting		
	Gambling		Perfectionism		
	Gender identity		Pessimism		
	Goals not being met		Phobias		