Gretchen Flores, LPC, LCPC
Licensed Clinical Professional Counselor

FIRST APPOINTMENT FORM

Please fill out the following form. All of this information will be kept confidential (note exceptions in the counselor disclosure form). Please keep your responses brief as we will have time to discuss them in further detail later. Please respond honestly as this will help me to assess your needs and decide the best course of action for you. Also please print legibly. Thank you! Only fill out what you are comfortable with.

CLIENT CONTACT INFORMATION:

Date: _____

Client Name:_____ Male ____ Female ____

Date of Birth: _____

Current Address:_____

_____

Parent/ Guardian Name (if under 18):_____

PHONE CONTACTS:

May I leave a message? (circle one)

Mobile Phone number:_____ Yes No

Home Phone number: _____ Yes No

Work Phone number: _____ Yes No

Other Phone number:_____ Yes No

Email address:_____ May I email you? Yes No

Referred by: _____

EMERGENCY CONTACT:

Name:_____

Phone Number:_____

I give my permission to contact this person in the case of an emergency: Yes No Initial_____

CURRENT CONCERNS:

What are your current primary concerns:

How severe is this difficulty? (check one)
_____Mild _____Moderate _____Severe _____ Incapacitating

When did this difficulty begin?

How often do you experience difficulty?

___Daily
___Weekly
___Monthly

Please explain:

Have you been in therapy or treatment in the past? How long ago?

Have you been hospitalized in the past? How long ago? What for?

Have you had suicidal thoughts? Yes No
Are you suicidal now? Yes No

If yes, please explain how often you feel this way and how intense your thoughts are:

If yes, what prevents you from following through on your thoughts?

If you are not suicidal, do you sometimes wish you just wouldn't wake up in the morning?

MEDICATIONS:
Please list current medications, dosages, and what they are for (Please be sure to fill this out).
None_____ (check if you are not taking medication)

	Medication:	For:	Dosage:	AM or PM?
1.				
2.				
3.				
4.				
5.				

List supplements that you take:

STRENGTHS AND RESOURCES:
What do you hope to get out of counseling?

What has helped you with this issue in your life (friends/family/community/group support)?

What do you consider to be **personal strengths** to help address this issue?

Do you have any hobbies?

Do you exercise? How often?

CURRENT SYMPTOM CHECKLIST: **Check and Circle all that apply:**

_____ Crying easily

_____ Sleep problems; Sleep too much Wakefulness Nightmares

Explain:

_____ Difficulty concentrating

_____ Anger

_____ Outbursts (Expressions of anger or frustration)

_____ Panic Attacks

Explain:

_____ Phobias/Fears

Explain:

_____ Memory loss

_____ Hearing voices

_____ Feelings of hopelessness

_____ Excessive fatigue

_____ Excessive energy Frequency: _____

_____ Excessive energy followed by excessive fatigue

_____ Obsessive (repetitive) thoughts About_____

_____ Obsessive actions (i.e. checking doors, washing hands)

Explain:

_____ Risk taking (i.e. overspending, driving too fast)

_____ Apathy or lack of enthusiasm about life

_____ Relationship problems/changes

_____ Eating problems; Overeating Under-eating Purging

Explain:

_____ Substance misuse; Alcohol Prescriptions Other drug _____

Explain:

_____ Suicidal thoughts; Attempts? Y N How long ago? Hospitalized? Y N

_____ Decrease in activities you used to enjoy

_____ Slowed bodily movements

_____ Worry About:_____

_____ Startle easily

_____ Indecisiveness

_____ Experienced a traumatic event

Explain:

_____ Negative self-perception

_____ Muscle tension

_____ Frequent headaches

_____Other Symptom that bothers you:

Explain:

EMPLOYMENT:
Name of Company:

Current Position:

Is your work satisfying to you?

HEALTH QUESTIONS:
Current physical health status: Poor Fair Good Excellent

Explain:
Do you drink diet soda? If so, how often?

Do you eat a healthy diet?

Do you use recreational drugs? What kind and how often?

Do you consider your recreational drug use to be a problem? Yes No

Do you drink alcohol? What kind? How often?

Do you consider the amount you drink to be a potential problem? Yes No

Has anyone told you that they thought your substance use was a problem? Yes No

FAMILY HISTORY:
Please check/circle all that apply:

____Parents divorced Age:
____Mother Remarried Age:
____Father Remarried Age:

____Depression	Paternal Side	Maternal Side
____Anxiety	Paternal Side	Maternal Side
____Alcohol/drug abuse	Paternal Side	Maternal Side
____Bi-Polar Depression	Paternal Side	Maternal Side
____Schizophrenia	Paternal Side	Maternal Side
____Other _____	Paternal Side	Maternal Side

PERSONAL HISTORY:
Have you experienced:
____Physical abuse
____Sexual abuse
____Emotional abuse
____Domestic Violence
____Other
Explain:

During your childhood who raised you?

What was your family like?

Relationship: Name of spouse or partner: _____

Single Married Separated

Divorced Widowed Common-law Married

What (if any) concerns do you have in your marriage/partnership?

Children:

	Name	Age
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	

SPIRITUAL PREFERENCES:
Please indicate your spiritual faith (If applicable):

How important are your personal spiritual beliefs?

____Not Important ____Somewhat Important ____Important ____Very Important

Are you involved in community in your faith? Yes No

Is there anything else significant that you think is important:

*Thank you. I look forward to working with you. ***This is an assessment only.*** Referrals to other supports or resources may be made, if deemed appropriate, to make sure you have the level of care that is the best fit for you.