Discovery and Wellness Counseling, PLLC Heidi Brouelette MA. LPC.
Scottsdale Office: 4300 N. Miller Rd. Suite 222 Scottsdale, AZ 85251
N. Phoenix Office: 34406 N. 27th Dr. Bld. 6, Suite140, Office103a Phoenix, AZ 85085
www.discoveryandwellnesscounseling.com / Hbrouelette@gmail.com
Phone: 480-677-9913 Fax: 623-223-1334

Date: _____

Name: _____ Birthday: _____ Age: _____

Address: _____

City: _____State: _____ Zip: _____

Cell Phone: _____Work Phone: _____

Home Phone: _____ Email:_____

May I mail to this address? Yes____ No____. May I e-mail to this address? Yes___ No____
How would you like to be reminded of appointments? Home phone____ Cell Phone ____Text____ E-mail_____
How would you like to receive messages and correspondences? Home____ Cell Phone____ Text____ Email_____.
Join Discovery & Wellness's mailing list: Yes ____ No____ Email you wish to use: _____

In case of an emergency whom should I notify? _____

Relationship to you: _____ Contact number: _____

Current Concerns
Briefly describe your reason for seeking help:

_____
_____
_____
_____
When did these problems begin? _____

On a scale of 1-10, rate you current level of distress: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Education
Level of education: HS_____ College_____ Graduate Degree_____ Other_____

Occupation:_____Employer:_____

How long have you worked there?_____How long in this occupation?_____

If not employed, how long has it been since you worked?_____

What kind of job did you have? _____

What caused you to stop working? _____

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Marriages/ Significant Relationships:

To Whom *Length of Relationship* *Termination of Relationship (if applicable)*

1. _____
2. _____
3. _____

Current Relationship Status:
Single____ Married____ Divorced ____ Separated____ Widowed____ Living Together_____

If married, separated, or living together, briefly describe you relationship:

_____

Has your spouse/ partner been previously married? Yes____ No ____ Number of times? _____
Number of children from pervious marriages: _____

Children(s) Names *Age* *Sex*

_____
_____
_____
_____
_____

Age of spouse/ partner: _____ Date of Birth: _____ Religion: _____

Level of education: HS _____ College_____ Graduate Degree_____ Other_____

Occupation: _____ Employer: _____

How long has he/she worked there?_____How long in this occupation?_____

Referral

If you found us on the Internet, please tell us how? (Check if applicable) Google ____Psychology Today ____

Good Therapy _____ Theravive _____ Discovery & Wellness website _____ Other_____

Who referred you to Discovery & Wellness? _____
May we thank them? Yes____ No____

If referred by a doctor, may we have permission to contact that doctor? Yes_____ No_____

Name: _____ Practice Name: _____

Address: _____ Phone: _____

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Extended Family: Parents, Siblings, and Others Close To You

Name	Relationship	Age	Occupation	Problems Alcohol/Mental/Emotional

How was it to grow up in your family?

_____
_____
_____
_____
_____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs	How do you get along?

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Medical History

Primary Care Physician: _____ Phone: _____

Date of last physical examination: ___/___/___

If you are taking any medications, please list:

Medication(s)-Prescription and Over the Counter	*Dosage*	*Prescribed For*

How would you describe your overall health: Excellent ___Good___ Fair___ Poor___

List any health problems for which you are currently receive treatment: _____

_____

List any past health problems including accidents: _____

_____

Do you exercise regularly? Yes____ No____ If yes, describe exercise and frequency _____

_____

Briefly describe your eating habits: _____

Have you ever had concerns about your eating habits? _____

Are you relatively satisfied with your appearance? _____

How much sleep do you get each day? _____ Describe your sleep habits: _____

_____

Psychological/ Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? Yes ____ No____
If yes, give a brief description of treatment & when it occurred? _____

_____

Have you ever thought about suicide? Yes____ No____ If so, did you have a plan? Yes ____ No ____
Have you ever attempted suicide? Yes ____ No ____ If so, how many times? _____
Have you ever felt homicidal? Yes ____ No ____ If so, did you have a plan? Yes____ No ____

Have you ever been inpatient for mental health reasons? Yes____ No ____
Intake Date: ___/___/___ Discharge Date___/___/___Reason: _____
Intake Date: ___/___/___ Discharge Date___/___/___Reason: _____

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Substances Used and/or Abused

Current	Past		Current	Past		Current	Past		Current	Past	
___	___	Alcohol	___	___	Prescription (RX)	___	___	Ecstasy	___	___	Barbiturates
___	___	Cocaine	___	___	OTC Medication	___	___	Opiates	___	___	Hallucinogens
___	___	Marijuana	___	___	Narcotics	___	___	Amphetamine	___	___	Other_____

Do you smoke Yes___ No___ If yes, how much/day? _____ Is this a concern? Yes ___ No ___
Do you feel you have a problem with drugs or alcohol? Yes____ No ____
Have you ever received treatment for drug or alcohol abuse/addiction? Yes ____ No ____
If yes, when and where? _____

Legal
Please list and describe any arrests or legal problems (including driving violations): _____
_____
_____
_____
_____

Please check all that apply:

Current	Past		Current	Past	
____	____	Depressed Mood	____	____	Recurrent and Persistent thoughts/behaviors
____	____	Daily Irritability	____	____	Difficulty controlling anger/bad temper
____	____	Physical abuse	____	____	No interest/pleasure in activities
____	____	Sexual abuse	____	____	Difficulty sleeping/ poor sleep
____	____	Increase/decrease need for sleep	____	____	Distressing memories that reoccur
____	____	Difficulty concentrating	____	____	Recurrent distressing dreams
____	____	Difficulty making decisions	____	____	Delusions (unreasonable thoughts/beliefs)
____	____	Fatigue or loss of energy	____	____	Do you hear or see things others do not?
____	____	Feelings of worthlessness	____	____	Not able to control the impulse to steal
____	____	Feelings of hopelessness	____	____	Preoccupation with or frequent gambling
____	____	Recurrent thoughts of death	____	____	Sense of reliving traumatic events
____	____	Racing thoughts or ideas	____	____	Periods of time you can't remember
____	____	Rapid mood swings	____	____	Intense reactions to certain events/anniversaries
____	____	Shortness of breath/dizziness	____	____	Avoidance of thoughts or feelings of trauma
____	____	Sweating/feeling flushed	____	____	Avoidance of activities or situation of trauma
____	____	Choking	____	____	Detachment from feelings, people, places
____	____	Nausea or abdominal distress	____	____	Binging/ compulsive overeating
____	____	Feeling unreal	____	____	Intentional vomiting
____	____	Numbness or tingling sensations	____	____	Laxative or diuretic use
____	____	Fear of dying	____	____	Excessive dieting
____	____	Sexual orientation issues	____	____	Compulsive sexual behaviors
____	____	Fear of going crazy	____	____	Accelerated heart rate/chest pains

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Circle any problem that pertains to you at the present:

Nervousness	Relaxation	Making Decisions	Stress
Shyness	Legal Matters	Self Control	Memory
Separation	Energy	Inferiority	Appetite
Drug Use	Loneliness	Bowel Troubles	Marriage
Anger	Education	Sexual Problems	Work
Sleep	Undereating	Alcohol Use	Overeating
Friends	Concentration	Nightmares	Temper
Fatigue	Ambition	Stomach Problems	Divorce
My thoughts	Parenthood	Health Problems	Age
Finances	My Appearance	Suicidal Thoughts	Future
Sexual Abuse	Children	Career Choices	Weight
Unhappiness	Depression	Headaches	Fears
Self-esteem	Sexual Orientation	Physical Abuse	

Circle everything that has happened to you in the past three years:

Death of a spouse/partner	Marriage Problems	Changes in marital status
Death of another family member	Family Problems (Children, in-laws)	Loss of Job
Major illness or injury–yourself	Financial Problems	Move to another city or state
Major illness or injury–family member	Legal Problems	Other: _____

Please list any additional information that you feel may be helpful _____