Diakonos, Counseling
General Patient Information

Date: ________________________

Patient Name: ____ SSN: ____-___-____

Date of Birth: ___ / ___ / ______ Gender: [ ] Male [ ] Female Ethnicity _________________

Home Address: ____
Street

____
City State Zip

Home Phone Number ________________________ May we leave a message? [ ] Yes [ ] No

Work Phone Number ________________________ May we leave a message? [ ] Yes [ ] No

Mobile Phone Number _______________________ May we leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:

Name of Guardian: ____

Address of Guardian: ____
Street

____
City State Zip

Guardian's Home Phone ______________________ May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone ______________________ May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone ______________________ May we leave a message? [ ] Yes [ ] No

If you will be using insurance to cover a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

Primary Insurance Company: ____

Secondary Insurance Company if applicable: ____

Referral Source

Who referred you to our office, or how did your learn about our practice? __________________________

____

Emergency Contact Information

In case of an emergency, who should we contact?

Name: _______________________________________ Relationship: _____________________

Phone Number: ________________________________

Diakonos, Inc.

History Information

Completing the following information as thoroughly as possible will help your therapist provide you the best treatment.

Who is providing the history information? [ ] The patient [ ] The patient's guardian

[ ] Other : ________________________

Please describe the current complaint or problem as specifically as you can, in your own words. ______________

____

How long have you experienced this problem, or when did you first notice it? ______________________________

What stressors may have contributed to the current complaint or problem?________________________________

____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Depression/sad/down ____
[ ] High/Low energy level ____
[ ] Angry/Irritable ____
[ ] Loss of interest in activities ____
[ ] Difficulty enjoying things ____
[ ] Crying spells ____
[ ] Decreased motivation ____
[ ] Withdrawing from people ____
[ ] Mood Swings ____
[ ]Change in weight or appetite ____
[ ]Suicidal thoughts or plans ____
[ ] Poor concentration ____
[ ] Feelings of hopelessness ____
[ ] Feelings of shame or guilt ____
[ ] Feelings of being cheated ____
[ ] Feelings of inadequacy ____
[ ] Anxious/nervous/tense ____
[ ] Panic attacks ____
[ ] Racing or scrambled thoughts ____
[ ] Bad or unwanted thoughts ____
[ ] Flashbacks ____
[ ] Muscle tensions, aches, ets. ____
[ ] Hearing voices ____
[ ] Seeing things ____
[ ] Thoughts of hurting people ____
[ ] Thoughts of running away ____
[ ] People our out to get me or hurt me ____
[ ] Feelings of frustration ____
[ ] Indecisiveness about career ____
[ ] Job problems ____
[ ] Other:____

Previous Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

Additional Information: ____________________

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

Additional Information: ____________________

List any current, or important past, medications

Medication & Dose	Date	Response
____________	______	____________
____________	______	____________
____________	______	____________

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or some one else? [ ] Yes [ ] No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? [ ] Yes [ ] No

If yes, explain: ____________________

Did you walk, talk, and read on time? [ ] Yes [ ] No, explain: ____________________

Medical History

History of serious childhood illnesses : ____________________

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: ____________________

Have you experienced any head injuries? [ ] Yes [ ] No Important Details: ____________________

If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No

Explain any allergies you have: ____________________

How would you rate your current physical health? [ ] Excellent [ ] Very Good [ ] Good
[ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health “check up?” ____________________

Do you have a primary care physician? [ ] Yes [ ] No If yes complete the following:

Name	Address	Phone
____________	____________	______

Family History

Birth Location ____________ Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father
[ ] Other: ____________________

Relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: ____________________

Father: ____________________

Other: ____________________

Other: ____________________

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
____________	______	____	____________

_________________________ __________ _____ _________________________________
_________________________ __________ _____ _________________________________
_________________________ __________ _____ _________________________________

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

____

Any family history of substance abuse, mental illness, suicide, or violence? ___________________________

Any Additional Family Information:____

Social History

Describe your relationship with peers and/or friends.? ____

How would you describe your social support network? ____

Describe your hobbies/interests: ____

Have you ever had concerns about being too “shy” or “timid”; or too “rambunctious” or “loud” socially?_________

____

Describe any cultural concerns: ____

What is your religious/spiritual background? ____

Do you wish to integrate religious/spiritual material as part of treatment? [ ] Yes [ ] No

Educational History

When attending school where you : [ ] In regular classes

[ ] Home Study

[ ] Special classes: _____________________________________

[ ] Ever suspended: ____________________________________

What is the highest educational level you have completed?______________________________________

Give any additional important educational information (i.e. Did you like school?):_______________________

____

Occupational History

What is your current employment status? [ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed

[ ] Self-employed [ ] Student

If employed, who is your employer? ______________________ What is your position: _______________

How would you describe your job satisfaction: [ ] Poor [ ] Fair [ ] Good [ ] Great

How would you describe your job performance: [ ] Poor [ ] Fair [ ] Good [ ] Great

What type of employment or training have you had previous to your current occupation? ________________

Marital History

Which best describes your marital status? [ ] Married, Date: ______ [ ] Never Married [ ] Widowed, Date: _____

[ ] Separated, Date: _____ [ ] Divorced, Date:_______

If you are married please briefly describe nature of your marital relationship:___________________________

If you are married, which best describes your marital satisfaction? [ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

First Name	Dates	Nature of Relationship
______________________________	______________	_____________________________________
______________________________	______________	_____________________________________
______________________________	______________	_____________________________________

Do you have children? [ ] Yes [ ] No If yes, complete the following?

First Name	Age	Gender	Nature of Relationship
_____________________________	__________	______	____
_____________________________	__________	______	____
_____________________________	__________	______	____
_____________________________	__________	______	____

Are there presently any child custody issues involving you or your family? [ ] Yes   [ ] No

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes [ ] No Additional Information: ____

Legal & Military History

Are you presently, or have you previously served in the military? [ ] Yes   [ ] No If yes complete the following:

Do you currently have any pending criminal charges? [ ] Yes   [ ] No

Have you ever been convicted of a crime? [ ] Yes [ ] No: If yes explain: __________________________

Does you family currently have Division of Family Services Involvement ? [ ] Yes   [ ] No

If yes please complete the following:

DFS Case Worker's Name : ____________________________ Phone: _________________

Additional Information

Summarize your goals for counseling/therapy: ____

____

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible? ____

____

____________________________________ ____________________________________

Signature of patient or guardian Date