EMILY GRIFFIN, M.A., LCPC

Clarity Through Counseling, LLC

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Initial Consultation Form

Date:_____

Client's Name _____ Age_____ Birthdate _____

Address _____ City _____

State _____ Zip _____ E-Mail _____

Home Phone _____Work Phone _____Cell Phone:_____

Preferred Method of contact (circle one) Phone call Text Message E-Mail

Parent Name (if client is under 18)_____

Occupation _____ Employer_____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____ Religion _____

Are You Taking Any Medication?_____If yes, what kind?_____

Reason for Medication: _____ Diagnosis? _____

Any Previous Therapy/Counseling? _____If Yes, Name and Phone Numbers of Therapists:

_____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

Who referred to Clarity Through Counseling, LLC: _____

Please state reason for working with Clarity Through Counseling, LLC:

Please tell me what you want to work on or change:

How long has this been a significant problem for you/them? *Please be specific (i.e., not "all my life").*

Please check any of the symptoms below that you/they have had in the past 6 months

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Nausea
- ☐ Not sure of myself
- ☐ Always Tired
- ☐ Lack of motivation
- ☐ Unable To Relax
- ☐ Insomnia
- ☐ Hopelessness
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Feel Guilty
- ☐ Feel Tense
- ☐ Feel Panicky
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Sadness
- ☐ Suicidal Ideas
- ☐ Helplessness
- ☐ Alcoholism
- ☐ Use of Drugs
- ☐ Allergy
- ☐ Asthma
- ☐ Questioning Sexuality
- ☐ Easily Angered
- ☐ Shy With People
- ☐ Difficulty Making Friends
- ☐ Afraid Of People
- ☐ Home Conditions Bad
- ☐ Unable To Have A Good Time
- ☐ Always Worried About Something
- ☐ Don't Like Weekends/Vacations
- ☐ Difficulty Making Decisions
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Gambling
- ☐ Performance Anxiety
- ☐ Difficulty Keeping A Job
- ☐ Other