Mosaics Counseling
3300 W Lake Mary Blvd., Ste. 340, Lake Mary, FL 32746
www.mosaicscounselingorlando.com

New Client Information Packet

Please print

General Information

Name: _____
First MI Last

Date of Birth: _____ Age: _____
Month Day Year

Gender/preferred pronoun(s): _____ Sexual/Affectional Orientation: _____

Race/Ethnicity: _____ Marital Status: _____

If in a relationship, for how long? _____ Level of Satisfaction of Relationship: _____
1 (poor)-10 (amazing)

Address: _____
Number Street City State Zip

Contact Information

Phone Numbers:

_____ _____ _____
Cell Home Work

Please circle your preference for communication: Cell Home Work

Is it okay to contact you at any of the numbers above? ☐YES ☐NO Comment: _____

Email: _____ Is it okay to contact you here? ☐YES ☐NO

Emergency Contact: _____
Name Relationship Phone Number

I understand that if my counselor feels I am in danger, she may break confidentiality and communicate with my emergency contact above. _____
Signature

Referred by: _____ Permission to thank for referral? ☐YES ☐NO

History and Medical Information

Briefly describe why you are seeking counseling:

_____
_____
_____
_____
_____

How severely would you rate this issue: ☐ Mild ☐ Moderate ☐ Severe

This issue affects ☐ Work ☐ Relationships ☐ Health ☐ Other: _____

Any recent changes in ☐ Weight ☐ Appetite ☐ Sleep ☐ Health ☐ Other: _____

If any recent changes are noted, please describe. _____

_____

How would you rate your level of anxiety? ☐ Mild ☐ Moderate ☐ Severe

How would you rate your level of depression? ☐ Mild ☐ Moderate ☐ Severe

Please name all household members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any family concerns relevant to your counseling? Please describe.

_____
_____
_____
_____
_____

Please check any areas of concern or distress.

___ stress
___ fears
___ unhappiness
___ headaches
___ impulsiveness
___ memory
___ low energy
___ motivation
___ panic attacks
___ relationships
___ racing thoughts
___ over/under eating
___ irritability
___ bad memories
___ avoiding feelings
___ social interactions
___ family problems
___ experienced a traumatic event
___ abusing alcohol
___ substance use

___ discrimination
___ concentration
___ parenting
___ low self-esteem
___ anger
___ work problems
___ "going through motions"
___ feeling sad often
___ feelings of worthlessness
___ seeing things others don't
___ avoiding thoughts/memories
___ nightmares
___ digestive issues
___ macroaggressions
___ cultural issues
___ making decisions
___ sexual issues
___ intimacy
___ can't stop crying
___ odd behaviors/thoughts

___ hearing voices others don't
___ feelings of hopelessness
___ nervous/shaky
___ bullying
___ finances
___ grief
___ jumpy
___ guilt
___ marriage
___ trouble relaxing
___ loneliness
___ restlessness
___ distrust
___ fogginess
___ sleep issues
___ flashbacks
___ harassment
___ other: _____
_____
_____

Have you ever experienced any of the following? Please circle.

Childhood neglect: **Y N not sure**
Childhood sexual abuse: **Y N not sure**
Rape/unwanted sexual contact: **Y N not sure**
Verbal abuse: **Y N not sure**
Physical abuse: **Y N not sure**
Domestic violence: **Y N not sure**
Emotional abuse: **Y N not sure**
Witness to violent/traumatic event: **Y N not sure**

Please list any stressful events you have experienced or witnessed that remain distressing on any level when you think about it. (For example: divorce, death of significant person in your life, illness, injury, discrimination, abortion, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Previous Counseling Experience

Please list and rate any prior counseling experiences.

_____

Name of counselor | Year(s) | Level of satisfaction 1(poor) – 10 (amazing)

_____

Name of counselor | Year(s) | Level of satisfaction 1(poor) – 10 (amazing)

_____

Name of counselor | Year(s) | Level of satisfaction 1(poor) – 10 (amazing)

Medications

Please list any past psychiatric medications and any current medications.

_____

Medication | Dose | Dates of use

_____

Medication | Dose | Dates of use

_____

Medication | Dose | Dates of use

_____

Medication | Dose | Dates of use

_____

Medication | Dose | Dates of use

_____

Medication | Dose | Dates of use

Alcohol, Substance Use, & Other Addictions

Please list past and present use.

Drug Name	Age(s) of use	Frequency of use	Effects
Drug Name	Age(s) of use	Frequency of use	Effects
Drug Name	Age(s) of use	Frequency of use	Effects
Drug Name	Age(s) of use	Frequency of use	Effects
Additional Addiction	Age(s) of addiction	Frequency	Effects

Diagnoses

Please list any diagnoses you have received in your life.

Diagnosis	Age of diagnosis	Medical professional who made diagnosis
Diagnosis	Age of diagnosis	Medical professional who made diagnosis
Diagnosis	Age of diagnosis	Medical professional who made diagnosis

Family History

Please list any family members who have experienced any of the following.

PTSD _____
Obsessive Compulsive Disorder _____
Schizophrenia _____
Suicide attempt/completion _____
Depression _____
Alcohol Use _____
Substance Use _____
Anxiety _____
Addictive Behaviors _____
Autism _____
Domestic Violence _____
Bipolar Disorder _____
Narcissism _____
Borderline Personality Disorder _____

Education & Employment

Please describe your level of education. _____

_____

Please describe your current employment situation. _____

Are you satisfied with your work? ☐ YES ☐ NO

Self- Assessment

What do you do to manage your stress? _____

_____

Do you consider yourself to be spiritual or religious? Please describe. ☐ YES ☐ NO

_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

Goals

If possible, please list 3-5 goals you have for counseling.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____ _____

Printed Name Signature Date