Bear Creek Family Behavioral Therapy Center

CLIENT INFORMATION

NAME: _____

Date of Birth: _____ SS# _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer: _____ Position: _____

EMERGENCY CONTACT:

Name: _____

Relationship to Client: _____ Phone #: _____

HEALTH INSURANCE COVERAGE:

Name of Insurance Company: _____

Plan or Policy #: _____

Individual ID #: _____ Group #: _____

Name of insured if different from client: _____

Referred by: _____

Previous Counseling (List Counselor's name(s) and approximate dates):

_____

Results of previous counseling: _____

_____

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CLIENT INFORMATION

MEDICATIONS - List all medications you are currently taking

1) Name: _____ Dosage: _____

Prescribed for: _____

2) Name: _____ Dosage: _____

Prescribed for: _____

3) Name: _____ Dosage: _____

Prescribed for: _____

4) Name: _____ Dosage: _____

Prescribed for: _____

CURRENT CONCERNS AND GOALS (List reasons for counseling at this time)

_____ _

_____ _

_____ _

Indicate everything you have experienced during the last six (6) months.

- ☐ Loss of job
- ☐ Sexual difficulties
- ☐ Pregnancy
- ☐ Involved in a lawsuite
- ☐ Changes in memory or attention
- ☐ Panic or anxiety attacks
- ☐ Death of a family member
- ☐ Weight loss or gain
- ☐ Difficulty thinking clearly
- ☐ Rape
- ☐ Verbal abuse
- ☐ Runaway
- ☐ Marital/Partner conflict
- ☐ Grief
- ☐ Problem solving
- ☐ Guilt/shame
- ☐ Work related issues
- ☐ Suicidal thoughts/attempts
- ☐ Stopped smoking
- ☐ New family member
- ☐ Alcohol or drug abuse
- ☐ Fiancial difficulties
- ☐ Self control problems (including anger)
- ☐ Increase number of arguments
- ☐ Nightmares
- ☐ Parent/Adolescent conflict
- ☐ Depression
- ☐ Decision making
- ☐ Anger control
- ☐ Divorce issues
- ☐ Relationships with others
- ☐ Low self esteem
- ☐ Parenting skill enhancement
- ☐ Hospitalization
- ☐ Traumatic event
- ☐ Retirement
- ☐ Feeling of worthlessness
- ☐ Time management problems
- ☐ Death of a close friend
- ☐ Authority issues
- ☐ Flashbacks
- ☐ Physical abuse
- ☐ Sibling conflict
- ☐ Major loss
- ☐ Personal achievement
- ☐ Inappropriate sexual behavior
- ☐ School issues

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CLIENT INFORMATION

Any other things you would like to share that are not listed on previous page:

_____

_____

_____

_____

_____

_____

_____

PERSON WHO COMPLETED THIS FORM

_____

Print Name

_____

Signature

_____

Date