Family Solutions Counseling, PLLC

10400 N. Vineyard Blvd. | Suite A | Oklahoma City, OK 73120

CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: □ M □ F Ethnicity _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Address: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail_____

Check if we can leave a message on: □ Home phone □ Work Phone □ Cell Phone

EMERGENCY CONTACT

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Other Phone: _____ Relationship: _____

HEALTH CARE RESOURCES

□ Private Insurance □ Public Insurance (Medicaid) □ None

Provider: _____ Policy/Medicaid Number: _____

Policy Holder (cite name as is appears on the insurance card): _____

Policy Holder Date of Birth _____ Group #_____

Please provide a copy of your driver's license and your insurance card.

CURRENT LIVING SITUATION

I live (check one): □ Alone □ w/Significant Other □ in Community Based Shelter

□ Other: _____ Number of Persons in Home: _____

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CHILDREN LIVING IN HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age ____ □ Male □ Female

Last Name: _____, First _____, MI ___ Age ____ □ Male □ Female

Last Name: _____, First _____, MI ___ Age ____ □ Male □ Female

OTHERS LIVING IN HOME (use back if needed)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ □ Male □ Female

City & State _____ If minor, with whom _____

Last Name: _____, First _____, MI ___ Age __ □ Male □ Female

City & State _____ If minor, with whom _____

FAMILY HISTORY

Have any members of your extended family suffered from or dealt with the following (check all that apply; use a separate sheet of paper if necessary):

□ Alcoholism (who? _____)

□ Drug Addiction (who? _____)

□ Sex Addiction (who? _____)

□ Workaholism (who? _____)

□ Gambling (who? _____)

□ Infidelity (who? _____)

□ Eating Disorder (who? _____)

□ Anxiety (who? _____)

□ Depression (who? _____)

□ Chronic Pain (who? _____)

□ Chronic Medical Condition (who? _____)

□ Hospitalized for Mental Health (who? _____)

CHIEF CONCERNS FOR SEEKING TREATMENT:

□ mood
□ anxiety
□ relationships
□ employment
□ memory
□ concentration
□ substance use
□ medical issue
□ recent event
□ other _____

REPORTED MOOD (on the day you filled this out):

□ euphoric
□ elated
□ cheerful
□ tranquil
□ euthymic
□ apathetic
□ dour
□ depressed
□ hopeless
□ suicidal
□ panicky
□ fearful
□ anxious
□ apprehensive
□ worried
□ calm
□ irritable
□ angry
□ enraged

RECENT STRESSORS: □ finance □ housing □ conflict □ work □ losses
□ medical □ transitions □ legal □ other _____

Please review the checked boxes and provide a brief description of your recent stressors in the space below:

MEDICATION: □ overuse □ as prescribed □ forgetful □inconsistent □resistant
□ dissastisfied □ discontinued

TOBACCO: □ in recovery □ non-user □ occasional □ social □ regular
□ heave use □ dependent □ type _____

ALCOHOL: □ in recovery □ non-user □ occasional □ social □regular
□ heave use □ dependent

Please review the checked boxes and provide a brief description of your alcohol use in the space below:

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If applicable, please provide a brief description of your spouse's or partner's alcohol use in the space below:

STREET DRUG: □ in recovery □ non-user □ occasional □recreational □regular
□ heavy use □ dependent

Please review the checked boxes and provide a brief description of your drug use in the space below:

If applicable, please provide a brief description of your spouse's or partner's drug use in the space below:

PHYSICAL HEALTH: □ robust □ healthy □ ill

In the space below, please provide information concerning current or chronic illnesses:

ACTIVITY: □ active □ fit □ average □ inactive □ lethargic

SLEEP: □ too much □ adequate □ insomnia □ restless

SOCIAL: □ non-stop □ highly active □ involved □ occasional □ rare □ isolated

WORK: □ workaholic □over working □ full time □ part time □ sporadic
□ unemployed □ refusal □ in school □ retired □ other _____

Please use provided space below to provide more information concerning work-related issues in your family (e.g., satisfaction, scheduling, spouse/partner issues).

Hobbies/Sports Activity: □ over involved □ highly active □ good balance
□ occasional □ rare □ absent

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Problems:

□ abandonment
□ abuse (child and/or adult)
□ addiction, sexual
□ addiction, alcohol
□ addiction, drugs
□ addiction, work
□ addiction, other
□ adjustment
□ affair/infidelity
□ alcohol
□ alienation
□ anger
□ anorexia
□ anxiety
□ avoidant
□ appetite
□ blended family
□ body image
□ bonding
□ boundaries
□ bulimia
□ child care
□ codependency
□ compulsivity, sexual
□ compulsivity, food
□ compulsivity, other
□ conduct
□ crisis
□ delusions
□ denial
□ depressed mood
□ depression, moderate
□ depression, severe
□ depression, in recovery
□ disability
□ disorganized
□ distractible
□ divorce
□ drugs
□ employment
□ emptiness
□ enabling
□ family conflict
□ fear
□ grief
□ guilt
□ hallucinations
□ hyperactive
□ idealistic
□ inactivity
□ inattention
□ inhibition
□ impulsivity
□ irritability
□ isolation
□ jealousy
□ legal problems
□ marital/couple
□ medical
□ memory loss
□ mood swings
□ obesity
□ obsessions
□ oppositional
□ overweight
□ overeating
□ undereating
□ pain
□ panic
□ pornography
□ rage
□ rejection
□ relational problems
□ self-worth
□ sexual abuse/assault
□ shame
□ social skills
□ sleep
□ stress
□ trauma
□ trust
□ worry

In the space below, after reviewing the checked items above, please write a brief summary of the problems for which you are seeking treatment:

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Strength & Virtues:

□ brave/courageous	□ creative	□ curious	□ open-minded
□ learner	□ persistent	□ integrity	□ vitality
□ kind	□ social	□ team player	□ fair
□ grateful	□ hopeful	□ humorous	□ playful
□ spiritual	□ generous	□ patient	□ level-headed

Support:

□ spouse/partner	□ nuclear family	□ extended family
□ close friend	□ group of friends	□ religious community
□ 12 step community	□ Service System	

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) _____

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) _____

History of Treatment

Are you currently under the care of a physician for medical problems/medication? □ YES or □ NO

If yes, describe: _____

_____

Physician Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Are you currently taking medications? YES or NO

If yes, list medications you are currently taking (use back if needed):

Strength & Dosage	Length Taken	Purpose & Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any allergies:_____

Are you currently receiving behavioral/mental health services elsewhere? YES or NO
If yes, provide the following:

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Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? YES or NO

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many self-help meetings have you attended in the past 30 days?_____

Other important information:

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