Elliot Swanson

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Today's Date:

General Information

Full Name:

Name You Prefer: Date:

Age: Date of Birth:

Street Address: Suite/Apt No.:

City: State: Zip Code:

Primary Phone: ( ) Secondary Phone: ( )

May I Leave a Message Here?: ☐ Yes ☐ No

Email Address:

May I Send Email Here?: ☐ Yes ☐ No

Emergency Contact

Name: Relationship:

Phone: ( )

Employment and Education

Employer: Length of Employment:

Occupation: Ave. Hours Worked Per Week:

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

Post Grad: ☐ Other:

Are You Currently In School: ☐ Yes ☐ No If Yes, What Level?:

Degree Pursuing:

Relationship Information

Current Status:

☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No ***If No, Briefly Explain:***

If Married, Separated, Divorced, or Widowed, How Long:

Number of Previous Marriages for You: Your Partner:

Partner's Name: Age:

Partner's Occupation:

Average Hours Worked Per Week:

What Words Would You Use to Describe Your Partner:

Is Your Partner Supportive of You Seeking Counseling:
☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*):
☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend
☐ Roommate(s) ☐ Other:

Children: List Your Children (Living or Deceased):

Name: Sex: Current Age:

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Name: Sex: Current Age:

Medical Information

Primary Physician: Phone: ( )

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No
If Yes, Please Specify:

List Any Relevant Medical Conditions: Mental Health Diagnosis, Illnesses,

Surgeries, Traumas or Related Treatments You Have Had *(Use Back if Necessary):*

Medications

List Any Current Medications You Are Taking (Use Back if Necessary):

Medication: Purpose:

Medication: Purpose:

Medication: Purpose:

Medication: Purpose:

Are You Taking these Medication(s) AS Directed? ☐ Yes ☐ No

If No, Briefly Explain:

Indicate Your Distress Level By Circling the Number on the Scale

(1 = Very Little Distress; 10 = Extreme Distress)

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Are You Currently Experiencing Any Suicidal Thoughts?:

☐ Yes ☐ No | Have You Experienced Them in the Past?: ☐ Yes ☐ No

Have You Ever Attempted Suicide?: ☐ Yes ☐ No | If Yes, When and How:

Have Any of Your Friends or Family Ever Committed or Attempted Suicide?:

☐ Yes ☐ No If Yes, When and Who:

Religious Background:

What Words Would You Use to Describe Yourself:

Briefly Describe the Religious Environment in Which You Grew Up:

Do You Regularly Attend a Place of Worship: ☐ Yes ☐ No | If Yes, Where:

Do You Have a Personal Support System: ☐ Yes ☐ No | If Yes, Who:

Previous Counseling

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: Location: Dates:

Reason:

Therapist: Location: Dates:

Reason:

Presenting Issues and Goals

What prompted you to seek to Counseling at this time *(i.e. What Are Your Issues, Problems?):*

Why Have You Decided to Come for Counseling Now:

What Do You Hope to Gain or Change by Coming for Counseling:

How Long Do You Believe Counseling Should Last:

Terms of Service

I Understand that Payment for Services Is Due When Services Are Rendered.
I accept Full responsibility for Payment of Any Balance Incurred for Services.
I further Understand that Without 24-Hour Notice of Intention to Cancel,
I will be Charged 1/2 Full Appointment Fee for Service.

Client Signature *Date*

by entering my name I am signing this document electronically,
the legal equivalent of my signature

(OR *Parent/Guardian of Minor)* *Date*