PINECREST COUNSELING

Please fill out the following information. All information you provide is protected under our privacy and confidentiality policy.

Kindly fill out this form and bring to your initial session.

Client name: _____
Full name

Name of Parent/Guardian (If under 18 years of age): _____
Full name

Date of Birth: _____ Age: _____ Gender: □ Male □ Female

Social Security: _____ Marital Status (Please check one):

□ Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

How Long: _____ With whom do you reside: _____

Please list names of children & ages: _____

_____

_____

Address: _____
(Number, street, and apt. or suite no.)

_____
City, state, and ZIP code

Home Phone: _____ May we leave a message? □ Yes □ No

Cell Phone: _____ May we leave a message? □ Yes □ No

Work Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

*Please note that electronic transmission is not considered to be a confidential medium of communication

Emergency Contact: _____
Full name

Relationship: _____ Phone number: _____

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Sunset Dr. Suite 203 Miami, FL 33173
12368 SW 82 Ave Pinecrest, FL 33156 9620

Who may we thank for your referral: _____

Have you previously received any type of mental health services? □ Yes □ No

If yes, when and for how long? _____

Previous therapist/practitioner: _____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, where, dates, diagnosis and length of stay: _____

_____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and include date: _____

_____

Have you ever had suicidal thoughts? □ Yes □ No

If yes, what was the outcome? _____

_____

_____

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How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific health problems you are currently experiencing? _____

_____

_____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific problems you are currently experiencing: _____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

_____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ Yes □ No

If yes, when did you begin to experience this? _____

_____

_____

Are you currently experiencing any chronic pain or had any recent surgeries? □ Yes □ No

If yes, please describe: _____

_____

_____

Are you currently in a romantic relationship? □ Yes □ No

If yes, for how long? _____

On a scale of 1-10 how you rate your satisfaction with this relationship? 1

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Are you currently experiencing any work related issues? □ Yes □ No

If yes, please briefly describe: _____

_____

_____

Are you currently experiencing any financial issues? □ Yes □ No

If yes, please briefly describe: _____

_____

_____

Are you currently experiencing inability to concentrate? □ Yes □ No

If yes, please briefly describe: _____

_____

_____

Are you currently experiencing excessive anger? □ Yes □ No

If yes, please briefly describe: _____

_____

_____

Are you currently experiencing any type of addictive behavior (ie. gambling, internet pornography)?

□ Yes □ No

If yes, please briefly describe: _____

_____

_____

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Please identify if there is a family history of any of the following. If yes, please indicate the family members relationship to you in the space provided.

Alcohol/substance abuse	□ Yes	□ No	_____
Anxiety	□ Yes	□ No	_____
Depression	□ Yes	□ No	_____
Eating Disorders	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive behavior	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____
Suicidal Attempts	□ Yes	□ No	_____

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Are you currently employed? □ Yes □ No

If yes, what is your current employment situation? _____

_____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

Do you have any legal issues □ Yes □ No

If yes, please explain: _____

_____

_____

What is the status of your case? _____

_____

_____

Are you spiritual or religious? □ Yes □ No

If yes, describe your faith or belief: _____

_____

_____

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

_____

_____

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

_____

_____

What would you like to accomplish and gain out of your time in therapy? _____

_____

_____

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