New Directions
Counseling Center

SOCIAL/MEDICAL INFORMATION

Today's Date:_____

Client Name:_____ DOB:_____/_____/_____

Please explain why you are seeking counseling at this time: _____

What do you hope to accomplish in counseling? _____

What do you think might get in your way of resolving problems or achieving goals?_____

Have you had ANY previous counseling experience? *(Please include type of treatment, medication, alcohol or drug treatment, hospitalization, name of therapist*) _____

Please describe your current medical condition and any significant medical history: (*Serious illnesses or major operations*):

Education: (L*ast grade completed, degrees earned, field of study*)_____

Military service: (*Type of discharge, number of years in service, active service*) _____

Accidents, sexual molestation, fears:_____

Legal problems:_____

How often do you exercise?_____ Average hours of sleep per night:_____
Hours you work daily:_____ When was your last vacation? _____

* *Please check any of the following that pertain to your situation:*

_____Anger/irritability	_____Loss/Grief	_____Career choices
_____Difficulty making decisions	_____Marriage/divorce	_____Finances
_____Friends	_____Headaches	_____Home conditions
_____Anxiety	_____Loneliness	_____Memory problems
_____Low Energy/Fatigue	_____Nightmares/dreams	_____Panic
_____Parenting	_____Phobias	_____Self-control
_____Self harm	_____Sexual problems	_____Sleep disturbance
_____Suicidal thoughts	_____Unable to concentrate	_____Unable to relax
_____Work	_____Worry	_____Migraine headaches
_____Depressed mood	_____Appetite changes	_____Low self-esteem

_____Alcohol use (*List type & amount)*_____
_____Drug use (*List type & amount)*_____
_____Caffeine intake (*List # of cups/bottles per day)* _____

Please specify any other symptoms you are experiencing: _____