Creason Counseling

5511 E. 82nd Street, Suite K
Indianapolis, IN 46250
317-721-9585

Today's Date _____

Client Information:

First Name:	Last Name:	Age:
Nickname:	Sex:	Birth date:
Occupation:	Employer:	Race:

Cell Phone: _____ Okay to call this number?_____Leave message? _____

Home Phone: _____ Okay to call this number?_____Leave message? _____

Home Address: _____
Street City State Zip

Email Address:_____Okay to email?_____

Have you ever sought counseling? Yes No

If yes, name of professional:_____Duration of counseling:_____

How were you referred to this center?_____

Describe the problem that brought you into counseling today:

Please check all the behaviors and/or symptoms that you consider problematic.

Distractibility		Change in appetite		Suspicion/paranoia	
Hyperactivity		Lack of motivation		Racing thoughts	
Impulsivity		Withdrawal from people		Excessive energy	
Boredom		Anxiety/worry		Wide mood swings	
Poor memory/ confusion		Panic attacks		Sleep problems	
Seasonal mood changes		Fear away from home		Nightmares	

Sadness/depression		Social discomfort		Eating problems	
Loss of pleasure/ interest		Obsessive thoughts		Gambling problems	
Hopelessness		Compulsive behavior		Computer addiction	
Thoughts of death		Aggression/fights		Problems with pornography	
Self-harm behaviors		Frequent arguments		Parenting problems	
Crying spells		Irritability/anger		Sexual problems	
Loneliness		Homicidal thoughts		Relationship problems	
Low self worth		Flashbacks		Work/school problems	
Guilt/shame		Hearing voices		Alcohol/drug use	
Fatigue		Visual hallucinations		Recurring, disturbing memories	

Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:

Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:

Have you recently been physically hurt or threatened by someone? If yes, please describe:

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Please check if you have experienced any of these types of trauma or loss:

Emotional abuse		Neglect		Lived in a foster home	
Sexual abuse		Violence in the home		Multiple family moves	
Physical abuse		Crime victim		Homelessness	
Parent substance abuse		Parent illness		Loss of a loved one	
Teen pregnancy		Placed a child for adoption		Financial problems	
Pregnancy Loss					

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

MEDICAL INFORMATION

Have you experienced any of the following medical conditions during your life?

Allergies		Asthma		Headaches		Stomach aches	
Chronic pain		Meningitis		Serious accident		Head injury	
Dizziness/fainting		Diabetes		Seizures		Vision problems	
High fevers		Abortion		Hearing problems		Pregnancy loss	
Sexually transmitted disease		Infertility		Sleep disorder		Other:	

Please list any current health concerns:_____

_____

_____

Primary Physician:

Doctor's Name:_____Type of Doctor: _____

Office Phone: _____ Fax: _____

Address: _____

Current medication prescribed:

Name of Medication	Dosage	Frequency	Start Date

PERSONAL INFORMATION

Employment:

Employer: _____ Position: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this position: Low Medium High

Other jobs you have held: _____

Education

Are you currently attending school? If yes, where?_____

Education History	Graduated?	Year	Area of study
High School			
GED			
Associates Degree			
Bachelor's Degree			
Professional Degree			
Other			

Military Service

Have you been/currently in military?	
Branch	
Date of Discharge	
Type of Discharge	
Rank	
Were you in combat?	

Legal

Have you ever been convicted of a misdemeanor or felony? If yes, please explain

Are you currently involved in any divorce or child custody proceedings? If yes, please explain

Spiritual

Do you consider yourself spiritual? If yes, please explain

Religious Affiliation:

Are you active with your faith?

Do you wish for this to be part of your counseling?

Are you satisfied with your social situation/interpersonal relationships? □ No □ Yes

If no, explain why:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies you use when stressed?

What are your overall goals for therapy?

What do you feel you need to work on first?

Is there anything that I did not ask about here that would be important for me to know about you?