

Human Connections Counseling Services
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Office: (214) 796-2323
www.MarriageCPR.com

Client Information

Today's date: _____

NOTE: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ calls will be discreet but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes ___ No ___

How did this person explain how I might be of help to you? _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes ___ No ___

D: Your current employer

Employer: _____

Address: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

ADULT HISTORY FORM

All information given by you or your family is confidential and may be released only with your consent.

Today's Date _____ Client Name _____ Birthdate _____

Marital status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widow|Widower

CURRENT PROBLEM (Please briefly describe when the problem started and why you're seeking help now.)

Education: ___ Grade School ___ High School Graduate ___ GED ___ College Graduate ___ Graduate Degree
Other _____

Educational or career goals: _____

Jobs held in last five years, including homemaker: _____

Describe any significant family of origin information which might have impacted your view of the world (such as relationships, family values, moving, divorce, deaths, illnesses, friendships, etc.)

PRESENTING PROBLEMS - CHECK ANY OF THE FOLLOWING ITEMS WHICH APPLY TO YOU

FAMILY

- difficulty with spouse or partner
- difficulty with parents
- difficulty with children
- difficulty with relatives
- away from home too much
- excessive arguing
- poor communication
- lack of understanding
- sexual relations
- physical abuse
- sexual abuse
- emotional abuse

ADDITIONAL INFORMATION

SOCIAL

- fear of social situations
- not liked by others
- lack companionship
- lonesome
- relationship problems
- religious problems
- financial problems
- legal problems
- gambling
- weight problems
- getting along with friends
- self-destructive
- too dependent on others

ADDITIONAL INFORMATION

SCHOOL

- learning disabilities
- behavioral
- achievements
- speech problems

ADDITIONAL INFORMATION

PHYSICAL

- past medical problems
- current medical problems
- pain
- muscle tension
- sleeping too little
- sleeping too much
- eating too little
- eating too much
- weight gain
- weight loss
- smoker/packs per day
- allergies
- stomach aches
- headaches
- feeling keyed up or on edge

ADDITIONAL INFORMATION

DRUGS/ALCOHOL

- self
- family

ADDITIONAL INFORMATION

- yes no Do you feel you're a normal drinker?
- yes no Do friends or relatives think you are a normal drinker?
- yes no Have you ever attended a meeting of Alcoholic Anonymous (AA)?
- yes no Have you ever lost friends of girlfriends/boyfriends because of drinking?
- yes no Have you ever gotten into trouble at work because of drinking?
- yes no Have you ever neglected your obligations, your family or your work for two or more days in a row because of drinking?
- yes no Have you ever had delirium tremens (DTs), severe shaking, bheard voices, or seen things that weren't there after heavy drinking?
- yes no Have you ever gone to anyone for help about your drinking?
- yes no Have you ever been In a hospital because of drinking?
- yes no Have you ever been arrested for drunk driving or driving after drinking?

WHIGH OF THE FOLLOWING (IF ANY) HAVE YOUR USED?

	Within 1 year	Past	Never	ADDITIONAL INFORMATION
Marijuana	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Pain Medication	_____	_____	_____	_____
Others	_____	_____	_____	_____

- yes no Have family or friends ever expressed concern over your use of drugs?
- yes no Have you over been arrested for any offense involving drugs?
- yes no Have you ever been treated for chemical dependency?
- yes no Have you ever overdosed on drugs (accidentally or purposefully)?

Family History	Name	Age	Emotional Problem (Describe)	Drug/Alcohol Problem (Describe)
Yourself				
Mother				
Step-mother				
Father				
Step-father				
Brothers				
Sisters				
Spouse				
Children				

Describe any developmental difficulties you might have had

How would you describe your mother?

How would you describe your father?

Your counseling or psychiatric history (past issues dealt with in therapy, past psychiatric hospitalizations, etc)

Current medications

Past psychotropic medications (such as for anxiety, panic, depression, mood imbalances, ADHD, etc)

What are some of your best strengths?

If things were as you wished, what would be different in your life right now?

Thank you for completing this intake information.