Saga Counseling Services

CLIENT PERSONAL DATA

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client: Name_____ Male☐ Female ☐

Address_____ City_____ Zip Code_____

Home Phone (___)_____ Work (___)_____ Cell (___)_____

May we call you at home? Y ☐ N☐ At Work? Y ☐ N ☐

Age: _____ Birthdate: _____ Highest Grade: Completed/Degree_____

Occupation: _____

Employer: _____ How Long? _____

Employer Address: _____

Ethnicity: Caucasian☐ African American☐ Hispanic☐ Asian☐ Other☐

NOTE: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy. Would you like spirituality/religious issues to be a part of your therapy?

Y☐ N☐ Don't Know☐ Church Affiliation (if any) _____

Are you a missionary or on staff at a church? _____

Person to notify in case of emergency: _____ Phone Number: _____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5

Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

FAMILY INFORMATION

Marital status - current: Single☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Partner ☐ Dating ☐

Spouse/Partner Name: _____ **Spouse/Partner Birthdate:** _____

Length of Marriage/Relationship: _____

Children: Names and Ages: _____

Are your children living with you? Yes ☐ No ☐

Parents: Father: Age_____ Occupation _____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ☐ N ☐ If your parents divorced, what age were you? _____

Did your parents remarry following divorce? Y ☐ N ☐ If yes, what age were you? _____

List names and ages of family members involved in therapy_____

_____

TREATMENT/THERAPY HISTORY

Are you currently in therapy elsewhere? Y / N

Have you ever had any previous counseling or psychotherapy? Y ☐ N ☐ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y☐ N☐ If YES, when? _____

If YES, method used:_____

Were you ever hospitalized for psychiatric reasons? Y☐ N☐ If Yes, when?_____ Length of stay_____

MEDICAL INFORMATION

Current Weight _____ One Year Ago _____ Maximum _____ When _____

Do you exercise regularly? Y☐ N☐ How? _____

Do you sleep well? Y☐ N☐ Amount (hours)_____ Easy to get to sleep? Y☐ N☐

Primary Physician_____ City_____ Date of last physical_____

Please list all current medications:

Medication	Dose	Reason

MEDICAL CONDITIONS

Please check all that apply:

	Never	Seldom	Sometimes	Often
Insomnia	☐	☐	☐	☐
Loss of Appetite	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Phobias (Fears)	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐
Loss of temper	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Depression	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Over-eating	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Self-harm Behaviors	☐	☐	☐	☐
Hearing/Seeing things that are not there	☐	☐	☐	☐

OTHER CONCERNS

Please check all that apply:

	Never	Seldom	Sometimes	Often
Smoking	☐	☐	☐	☐
Packs per week: _____				
Alcohol Intake	☐	☐	☐	☐
Frequency (per week): _____				
How Much? _____				
What do you drink? _____				
Marijuana	☐	☐	☐	☐
Amount per week _____				
Drugs (not medications)	☐	☐	☐	☐
What? _____				
Frequency _____				

MEDICATION HISTORY

Please check all that apply:

	Never	Seldom	Sometimes	Often
Appetite Suppressants	☐	☐	☐	☐
Pain Relievers	☐	☐	☐	☐
Sedatives/Tranquillzers	☐	☐	☐	☐
Sleep Aids	☐	☐	☐	☐
Stimulants	☐	☐	☐	☐
Blood Pressure Meds	☐	☐	☐	☐
Heart Medicine	☐	☐	☐	☐
Vitamins	☐	☐	☐	☐

Please list all current medications:
Comments: