FAMILY RENEWAL
counseling

Thank you for choosing Family Renewal Counseling, LLC. We appreciate your trust in our services. This form will enable us to gain a quicker understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. ***If you are a couple, please fill out two forms, one for each person.***

Client Name:_____ Age:_____

Date of Birth _____ SSN_____

If student_____
School Grade (ex 7th, 10th) or College Class (ex. Freshman)

If employed:_____
Employer Occupation

Referred by_____May we thank them?_____Y _____N

Home address_____
Street City State Zip

Permission to send mail to above address: _____Y _____N

Marital status: _____Single _____Engaged _____Married _____Divorced _____Widowed

Contact Information:	**Permission to Call:**	**Permission to Leave Message**:
Home phone_____	_____Y_____N	_____Y _____N
Work phone _____	_____Y _____N	_____Y _____N
Cell phone _____	_____Y _____N	_____Y _____N

Email_____ Permission to use _____Y _____N

Would you like appointment reminders at this email address?_____Y _____N

In case of emergency contact:_____
Name Phone

Insurance Info. (If applicable) Fill out only if you wish us to file.

Insured's name_____D.O.B_____

Relationship to client_____ SSN_____

Name of Insurance Co._____

Group #_____ ID#_____

Phone#_____ Employer_____

Person responsible for charges_____

Address & phone if different_____

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Other Payment Assistance. **Fill out only if you wish us to charge the assisting party.**

Name of person or organization:_____

Contact person and agreed arrangement: _____

_____

Secondary Insurance Info. (If applicable) Filling this out gives us permission to file if necessary.

Insured's name_____D.O.B_____

Relationship to client_____ SSN_____

Name of Insurance Co._____

Group #_____ ID#_____

Phone#_____ Employer_____

Person responsible for charges_____

Address & phone if different_____

Primary Care Physician_____
Name Address Phone

Total gross family income _____

*****In order to file insurance, benefits must be assigned. Otherwise, your payment will be full fee at time of service and not your co-pay. Do you agree to assign benefits to Family Renewal Counseling Center, LLC?**

_____yes _____no***

Religious/Cultural Background

What is your ethnic/cultural background?_____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? _____yes _____no If yes, where do you attend? _____

_____

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Medical History

Current Health Status. Please list any illnesses, medications and prescribing physicians.

Illness	Medication or Supplement	Dosage/Frequency	Prescribing Physician

Please list the name of your primary care provider _____

Nutrition

Have your eating habits changed recently? _____yes _____no

Has your weight fluctuated more than 10lbs. over the past year? _____yes _____no

Do you often eat of boredom, depression, anxiety or anger? _____yes _____no
Circle if applicable.

Do you ever self-induce vomiting? _____yes _____no

Do you ever binge eat or feel your eating is out of control? _____yes _____no

Do you use laxatives, water pills or diet medications? _____yes _____no

How do you feel about eating with others in a group? _____

Substance Abuse History

	First Use	Last Use	Average Amount	Frequency of Use
Caffeine				
Alcohol				
Nicotine				
Marijuana				
Pain Medication Type_____				
Meth				
Heroin				
Cocaine				
Pornography				
Sex				
Gambling				
Other_____				

Have you experienced a recent increase in your alcohol or other substance abuse? _____yes _____no

Do you see your current usage as a problem? _____yes _____no

Is there a history of alcohol/drug/substance abuse in your family? _____yes _____ no If yes, who? _____

Other Health Information

Have you ever been diagnosed or treated for depression, anxiety, or other mental/emotional issue? ____y ____n

If yes, please explain condition, treatment and person who treated you:_____

_____

Have you received previous counseling or psychiatric care? ____y ____n If so, please explain reason for seeking

care and therapist, psychologist or psychiatrist whom you saw _____
circle one

_____

Have you ever cut or harmed yourself intentionally? _____y _____n If yes, please explain type of harm, frequency, first incident and last incident _____

Have you ever attempted suicide or homicide? _____ y _____n If yes, please explain method, date and reason for attempt. _____

_____

Are you currently suicidal or homicidal? _____y _____ n If yes, please explain any plan you may have and whether or not you have access to this plan?_____

_____

Has there ever been or is there currently physical violence in your home including shoving or hitting? ____y ____n If yes, please explain types of physical violence and approximate time frame._____

_____

Do you feel unsafe with any family member in your home? ____y ____n If yes, please explain _____

_____

Developmental History

List members of your family with whom you grew up:

_____ _____ _____

_____ _____ _____

What was your birth order? ____ of _____children. Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful Happy
Please circle one

What is your sexual orientation? Heterosexual Homosexual Bisexual Transgender
Please circle one

What were you like as a child? Ex. Sad, shy, outgoing, friendly, contrary, rebellious, etc. _____

_____

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Family and Support System

With whom do you currently live?

Name	Relationship to You	Birthday/Age	Biological, Step, Adopted, Foster	Custody?	Children Not in Home/Age

Any history of miscarriage, infertility or abortion? ___y ___no If yes, please explain _____

Would it be beneficial for any of your family members to be involved in your treatment? _____yes _____no If yes, whom do you believe would be helpful?_____

Whom can you count on for support? _____

_____

Previous marriage? _____ yes _____ no If yes, date of divorce _____

What is your perception of your current marriage? (Include communication patterns, problems, sexual relations etc.) _____

_____

Work History

Describe your current job/career _____

Would you enjoy this on a long-term basis? _____

If you could have any job/career, what would it be? _____

How do you deal with authority figures? _____

Describe your relationship with co-workers _____

Legal History Circle all that apply:

Charges as a Minor	Present Charges	Arrests	Incarcerations	Parole Convictions
Bankruptcy	Probation	DUI	Civil Suit	Other_____

Please give details of legal issues _____

_____

Educational History

Highest level achieved _____ What type of grades did you make? _____

Are you currently in school? -_____yes _____no What grade/level/major? _____

Concerns Check List Circle all that apply:

Anger	Depression	Education	Eating difficulties
Fearfulness	Nervousness	Financial problems	Marital problems
Coping with illness	Social relationships	Problems with children	Abuse
Problem with parents	Spiritual concerns	Sexual concerns	Thoughts of suicide
Trouble making decisions	Unhappy most of the time	Use of alcohol	Use of drugs
Work related	Grief	Worry/Anxiety	Divorce recovery
Other _____	Cutting, burning, self-harm	Thoughts of harming someone else	Spousal affair/Affair

Please briefly describe your presenting concerns: _____

_____

_____

What are your goals for therapy? _____

_____

_____

How would you know your goals were met? _____

_____

Any additional information you would like us to know? _____

_____

Any additional information you were hesitant to tell us? _____

_____

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