BRITTANI PERSHA COUNSELING

Child and Family Counseling Services

Welcome to Brittani Persha Counseling. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Client Contact Information

Name: _____ Today's Date: _____

Address: _____

City: _____ Prov/State: _____ Zip/Postal Code: _____

Home phone: _____ Cell number: _____

Email address: _____ Receive email at this address? Y: ___ N: ___

Age: _____ Birthdate: _____ Birthplace: _____

Education (grade completed, any postsecondary): _____

Current Occupation: _____

At which phone number do you prefer to receive calls & voicemails? Home: ____ Cell: _____

How do you prefer to receive automated appointment reminders? Text: _____ Email: _____

How did you hear about us? Insurance: ___ Psychology Today: ___ Practice Website: ___

Referred by a doctor or other clinician: ___ (Please list name here: _____)

Referred by friend or family member: ___ Other: ___ (List here: _____)

Emergency Contact Information

Person to alert in the event of medical/mental health emergency: _____

Relationship to you: _____ Phone: _____

Physician Information

Family Doctor: _____ Phone: _____

Psychiatrist Name: _____ Phone: _____

Current Medications: _____

Financially Responsible Person's Information

(If other than the client)

Name: _____ Relationship to Client: _____

Address: _____

Phone: work_____ cell_____

Client's Insurance Information

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ DOB: _____ Employer: _____

ID #: _____ Group #: _____ Subscriber's SSN: _____

Background Information

Briefly describe why treatment is being sought: _____

_____

_____

Have your ever sought counseling before? Yes No

If yes, where and when? _____

Have you ever been in psychiatric hospitalization? Yes No

If yes, date: _____ Describe: _____

_____

Are you currently experiencing any physical health problems? Yes No

If yes, describe: _____

_____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's name: _____ Age: ___ Yrs in relationship: _____

Children: (Include and indicate step-children)

Name	Gender	Age	Name of Other Parent	Lives w/ you?

Parents:

Name	Age	Lives where?	Important Information

Siblings:

Name	Age	Lives where?	Important Information

Do you or any of your blood relatives struggles with any of the following:
ADHD ☐ yes ☐ no Relationship _____
Learning Disabilities ☐ yes ☐ no Relationship _____
Depression ☐ yes ☐ no Relationship _____
Alcohol/Drugs ☐ yes ☐ no Relationship _____
Suicide ☐ yes ☐ no Relationship _____
Anxiety ☐ yes ☐ no Relationship _____
Rage ☐ yes ☐ no Relationship _____
OCD Tendancies ☐ yes ☐ no Relationship _____

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If yes, describe: _____

_____

Do you have any past history of physical, emotional or sexual abuse? Yes No

If yes, any information you feel comfortable sharing: _____

_____

In the past few years have you been through any stressful experiences (ex: death of a family member, move, changes in family, loss of a job, ect.)? _____

_____

Symptoms Checklist

Directions: Read through the list of symptoms below. Then, rate the ones you are experiencing on a scale from one to three in the corresponding fields (1 = mild, 2 = moderate, 3 = severe)

Emotional Concerns

	Feeling anxious or uptight
	Excessive worrying
	Not being able to relax
	Unable to calm yourself down
	Dwelling on certain thoughts or images
	Fearing something terrible is about to happen
	Avoiding certain thoughts or feelings
	Having strong fears
	Feeling out of control
	Fears of being along or abandoned
	Feeling guilty
	Having nightmares
	Flashbacks
	Troubling or painful memories
	Trouble remembering things
	Feeling numb instead of upset
	Feeling detached from all or part of your body
	Feeling unreal, strange or foggy

	Feeling unmotivated
	Loss of interest in many things
	Having trouble concentrating
	Having trouble making decisions
	Feeling the future looks hopeless
	Feeling worthless or like a failure
	Being unhappy all the time
	Dissatisfied with physical appearance
	Feeling self critical or blaming yourself
	Having negative thoughts
	Crying often
	Feeling empty
	Withdrawing inside yourself
	Thinking too much about death
	Thoughts of hurting yourself
	Frequent mood swings
	Feeling resentful or angry
	Feeling irritable or frustrated
	Feeling rage
	Feeling like hurting someone
	Having obsessive/ruminating thoughts

Behavioral and Physical Concerns

	Not having an appetite
	Having obsessive behaviors such as: hand-washing, checking, counting, ect.
	Eating in binges
	Self induced vomiting for weight control
	Using laxatives for weight control
	Eating too much
	Eating too little
	Trouble finishing things
	Cutting or harming self
	Trouble sleeping
	Trouble falling asleep
	Early morning awakening
	Sleeping too much
	Sleeping too little

	Excessive exercise
	Not having leisure activities
	Often spending in binges
	Working too hard
	Using alcohol too much
	Being alcoholic
	Using drugs
	Driving under the influence
	Blackouts- after drinking
	Lack of exercise
	Aggressive towards others
	Losing weight
	Gaining weight
	Avoiding being with people
	Being tired and lacking energy
	Impulsive reactions

Intimate Relationship Concerns

	Feeling misunderstood in relationship
	Not feeling close to partner
	Trouble communicating with partner
	Not trusting partner
	Disagreeing about children
	Unsatisfactory sexual relationship
	Lack of time together
	Lack of shared interests
	Lack of positive interaction
	Frequent arguments

	Trouble resolving conflict
	Partner being demanding and controlling
	Violent arguments
	Emotional abuse in relationship
	Sexual abuse in relationship
	Partner having alcohol or drug problem
	Self or partner having an affair
	Feeling uncommitted in relationship
	Discussing separating or divorce
	Problems with ex-partner, in-laws, step parents

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

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