CLIENT REGISTRATION & INFORMATION

Next Chapter Counseling, LLC
Deborah S. Wood, LPC, RN, NCC

PLEASE COMPLETE PRIOR TO FIRST APPOINTMENT.

Name: _____

Address: _____

City: _____ State: _____Zip:_____

Cell Phone: _____ Work Phone: _____Home Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Gender: Male ____ Female _____

Occupation: _____ Employer: _____

Relationship Status:

Single: ____ Living with boy/girlfriend: ____ Married: ____ Divorced: ____ Widowed: ____

Education Level: _____ Present or last school attended: _____

Emergency Contact: _____

Phone: _____ Relationship to client: _____

Responsible Party: _____

Relationship to client:_____

How did you hear about Next Chapter Counseling? _____

Referred by? _____

Medical History:

Primary Care Physician Name: _____ Phone:_____

Last Visit: _____ Reason: _____

Last Complete Physical: _____ Weight: _____ Height: _____

Medical Conditions: _____

_____

_____

_____

Allergies and type of reaction:_____

_____

_____

_____

Please list all prescribed and over the counter medications, dose, prescribing physician, and how long you have taken each: (Use additional sheet if needed)

1._____

2._____

3._____

4._____

5._____

6._____

Have you been seen by a *mental health professional* in the past for assessment, testing, medication or counseling? If yes, please explain:

_____

_____

_____

Have you ever been hospitalized for Medical care: Yes ___ No ___ Psychiatric care: Yes ___ No ___

If yes, please provide the following information:

Date: _____Facility Name & Location:_____

Reason: _____

Date: _____Facility Name & Location:_____

Reason: _____

Date: _____ Facility Name & Location:_____

Reason: _____

Please check any of the following that you have ever experienced and *CIRCLE* any of the following that you have experienced in the last 6 months.

____Physical Health Problems

____ Chronic Pain Cause? _____

____Headaches Known cause? _____

____Head Trauma Cause? _____

____Psychological Trauma

____Abuse: Physical ____ Verbal ____ Emotional/Psychological ____ Sexual ____

____Problematic Anger

____Sleep Difficulties

____Nightmares

____Drug/Alcohol Difficulties Which drugs?_____

____Sexual Difficulties

____Frequent Crying

____Sadness

____Grief/Loss

____Low Self-esteem

____Low Motivation

____Fatigue/Low Energy

____Concentration/Focus Issues

____Memory Difficulties

____Loneliness

____Anxiety

____Depression

____Obsessive Thoughts/Behaviors

____Self-control Difficulties

____Self-Harming Behaviors

____Suicidal Thoughts

____Suicide Attempts How many?_____ When?_____

____Eating issues Anorexia_____ Bulimia_____ Binge Eating _____ Other_____

____Weight Loss/Weight Gain_____

____Social Difficulties

____Parenting Difficulties

____Marital/Relationship Difficulties

____General Stress

____Employment/Career Issues

____Psychosis

____Other:_____

Please check any of the following that have been present in the family (including extended family on mother and father's sides) and indicate which relative dealt with the issue.

____ Anger/violence _____

____ Attention Deficit Disorder (ADHD)_____

____ Drug/Alcohol Abuse_____

____ Eating Disorders_____

____ Learning/Developmental Disabilities_____

____ Mental Illness_____

____ Physical Abuse_____

____ Sexual Abuse _____

____ Suicide_____

Religion/Spirituality:

How important is religion/faith to you: Very Important_____ Somewhat important _____

Not important at all _____

How often do you attend religious services? _____

Particular denomination? _____

Do you have concerns/issues related to religion/faith? Yes _____ No ____

Would you like to have religion/faith incorporated into your counseling sessions? Yes ____ No____

Briefly state why you are seeking help at this time:

_____

_____

_____

_____

Please estimate the severity of your current problems using the scale below:

Mild: ____ Moderate: ____ Severe: ____ Extremely Severe: ____ Incapacitating: ____