Stiles Counseling Services

Client Information

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY.
IF COMING AS A COUPLE, EACH PERSON NEEDS TO FILL OUT HIS/HER OWN FORM.

First Name _____ MI ____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____

May we call you at home? Y N At work? Y N On your cell? Y N
May we leave a message at home? Y N At work? Y N On your cell? Y N

Birthdate _____ Age _____ Gender ___ F ___ M Race _____

Marital Status ____ single ____ married ____ divorced ____ widowed ____ other (_____)

Name of Spouse/Partner _____ Phone (Home) _____ (Cell) _____

Children ___ Y ___ N If yes, how many? _____ Living at home? _____ Step-Children? _____

Gender & Ages _____

Education: Check the box that applies to you.

☐ Some H.S. ☐ High School Graduate ☐ GED ☐ Technical/Trade
☐ Some College ☐ College Graduate ☐ Post-Graduate Work

Profession: _____ Employer: _____

In case of emergency, I give my permission to contact:

Name _____ Relationship _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Referral Source:

How did you hear of our office (or from whom)? _____

E- Mail Address _____ Add to e-newsletter list? ____Y ____ N

Ok to email regarding appointment dates/times? ____Y ____ N

Are you considering using Insurance? ____Y ____ N If yes, which carrier/plan? _____
(Please fill out Insurance Verification Form & return prior to your 1st appt.)

Client Signature _____ Date _____

Name _____

Date of last medical exam? _____

Psychiatrist _____ Phone _____

Address _____ City _____ State _____ Zip _____

PERSONAL CONCERNS: (Please check if concerns apply, if not leave blank).

Past	Present		Past	Present	
		Thoughts about hurting yourself			Thoughts about hurting others
		Thoughts of ending your life			Anger
		Suicide attempt(s)			Anxiety / Excessive worry
		Flashbacks or nightmares			Panic attacks
		Physical Abuse			Difficulty in concentrating
		Sexual Abuse			Racing thoughts
		Verbal/Emotional Abuse			Paranoia
		Legal issues (DUI, bankruptcy, arrestes, etc.)			Hallucinations
		Gambling Problem			Blackouts (period of time you don't remember)
		Compulsive Spending			Eating Disorders/Body Image Concerns
		Shoplifting / theft			Marital Concerns
		Obsessions/Compulsions			Sexual Difficulties
		Hoarding (excessive accumulation of items)			Pornography
		Alcohol Problem			Parenting / Child Concerns
		Drug Problem			Career Issues / Difficulties at work

What concerns or issues convinced you to seek assistance now? _____

_____

_____

How long has this been a concern?_____

SUPPORTS:

Do you feel comfortable discussing difficulties with family or friends? _____

Who do you turn to for emotional support or help with your problems?_____

Are your religious or spiritual beliefs a source of support? _____

Is there a history of mental health problems in your family? Yes ☐ No ☐ _____

Is there a history of substance abuse in your family? Yes ☐ No ☐ _____

Please rate the following (based on past month):

Anxiety/Worry _____ Extremely high _____ High ____ Moderate ____ Low ____ None

Depression _____ Extremely high _____ High ____ Moderate ____ Low ____ None

Stress Level _____ Extremely high _____ High ____ Moderate ____ Low ____ None

Name _____

Have you ever used?

	Never	Yes, Earlier in Life	Yes, within the last months	Frequency and Amount
Tobacco				
Alcohol				
Street Drugs				

PREVIOUS COUNSELING:

Have you had previous counseling or are you currently in treatment with any other mental health provider?

Yes ☐ No ☐ If yes, with who? _____

name phone #

Please list all mental health and/or substance abuse treatment you have had.

Date(s)	Counselor/Treatment Program	Reason(s) for Treatment

Please list any current medications and/or supplements that you are taking for your emtional/mental well being?

_____

What medications have you taken in the past for your emotional/mental well being? _____

_____

PHYSICAL HEALTH:

How is your physical health? _____Good _____Fair _____ Poor

Please mark all Past and/or Present conditions or concerns. Leave blank if not applicable.

Past	Present		Specify	Any Medications Prescribed?
		Allergies		
		Adverse reactions to medications		
		Digestive problems/gastrointestinal		
		Weight gain/loss		
		Appetite Loss		
		Heart		
		High / Low Blood Pressure		
		Thyroid		
		Lungs/respiratory/breathing		
		Diabetes		
		Sleep difficulties _____		
		Seizures		
		Head injury		
		Auto Immune disorders		
		Other _____		

Overall, how is your life going now, compared to a year ago? _____ Much Better _____ Better _____ Same _____ Worse _____ Much Worse

Any other health issues or concerns? _____

_____