Chapin Faulconer, LPC
1 Boar's Head Place, Suite 102
Charlottesville, VA 22903

Client Information

Name: _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Which number do you want us to use when calling you about an appointment? _____

Please state restrictions on our use of your phone numbers when calling you. _____

_____

DOB: __/__/__ Age: ___ SSN: _____-____ -_____ Sex: F ___ M ___

Relationship Status (circle one): Single Married Divorced Significant Other Partner

If a minor, give parents' names: _____

Are parents separated or divorced? ___ Yes ___ No If yes, with whom does child live? _____

If yes, does child visit the absentee parent? ___ Yes ___ No Explain: _____

If child has guardian please give name: _____

Please list those living in your home:

Name	*Relationship*	*Age*	*Gender*	*Grade in School or Job*

Education: _____

Occupation: _____

Referral Source: _____

Reason for Seeking Services: _____

Name 2 goals for counseling:

1. _____

2. _____

Medical History Form

Name: _____ DOB: __/__/__ Sex: ___ SSN: _____

Primary Care Physician Name: _____

Address: _____ Phone: _____

Are you currently being treated for an emotional or medical condition? Yes ___ No ___

If yes, please describe: _____

_____

_____

List chronic illnesses or health conditions (including allergies) and treatment: _____

_____

Check or write DK (don't know) if your family has a history of: Depression ___ Suicide ___ Anxiety __

Substance Abuse ___ Eating Disorders ___ Other ___ Please describe: _____

_____

Are you taking any prescription or over the counter medication? Yes ___ No ___ If yes, please indicate:

Medication	Dosage	Frequency	When Started	Prescribing M.D.

Have you ever been hospitalized? Yes __ No __ If yes, please complete the following.

Reason: _____

Dates: _____

Have you been in therapy or counseling before? Yes ___ No ___ If yes, please describe:

Reason	Dates	Length	Therapist	Effective?

Emergency Contact and Insurance Information

Emergency Contact Information:

Contact Person: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Work) _____ (Home) _____ (Cell) _____

Insurance Information (if applicable):

Insurance Company: _____

I.D. Number: _____ Group Number: _____

Your Employer: _____

Your Primary Care Physician: _____

If you are not the policy holder: please complete:

Name of Policy Holder: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder's Employer: _____

Intake Assessment

What is happening in your life which resulted in this appointment?

What would you like to see accomplished in therapy?

CHECK ALL THAT APPLY TO YOU:

- o Depression
- o Crying spells
- o Low energy
- o Low self-esteem
- o Poor concentration
- o Hopelessness
- o Worthlessness
- o Guilt
- o Sleep disturbance (more/less)
- o Appetite disturbance (more/less)
- o Thoughts of hurting yourself
- o Thoughts of hurting someone else
- o Isolation/social withdrawal
- o Sadness/loss
- o Stress
- o Anxiety/Panic
- o Heart pounding/racing
- o Chest pain
- o Trembling/shaking
- o Chills/hot flashes
- o Tingling/numbness
- o Fear of dying
- o Fear of going crazy
- o Nausea

- o Phobias
- o Obsessive/compulsive behaviors
- o Thoughts racing
- o Difficulty concentrating
- o Easily agitated/irritable
- o Excessive behaviors (spending, gambling)
- o Anger/frustration
- o Excessive use of drugs and/or alcohol
- o Physical Abuse issues
- o Sexual abuse issues
- o Spousal abuse issues
- o Relationship problems
- o Separation/divorce
- o Employment issues
- o Other problems/symptoms:

_____

_____