RESET COUNSELING, LLC

Date: Patient Name:

Social Security Number: Date of Birth:

Home Address:

Preferred Phone Number: May we leave a message? [ ] Yes [ ] No

Alternate Phone Number: May we leave a message? [ ] Yes [ ] No

Referral Source

Who referred you to our office, or how did your learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name: Relationship:

Address: Phone Number:

Personal History

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence

[ ] High/Low energy level

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc,)

[ ] Depression/Sad/Down feelings

[ ] Self-harm/Cutting/Burning yourself

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of shame or guilt
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Hearing voices/Seeing things not there
[ ] Perfectionism
[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Have you had hospital stays for psychological concerns?

[ ] Yes [ ] No

Additional Information:

Are you experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past? [ ] Yes [ ] No

Medical History

List any current or important past medications

Medication & Dose: Response to Medication:

History of serious childhood illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

How would you rate your current physical health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health “check up?”

Do you have a primary care physician? [ ] Yes [ ] No

If yes, complete the following:

Name

Address

Phone Number

Family History

Birth Location:

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other:

Relationship with parent figures:

(good, fair, poor, close, distant, etc.)

List your siblings and describe your relationship with them?

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History

When attending school where you:

[ ] In regular classes [ ] Home Study [ ] Special classes [ ] Advanced classes [ ] Other

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed

[ ] Self-employed [ ] Student [ ] Other

Are you satisfied with your employment situation?

If not, why?

Marital History

Which best describes your marital status?

[ ] Married, Date: ______ [ ] Never Married [ ] Widowed, Date: _____

[ ] Separated, Date: _____ [ ] Divorced, Date:_______

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction?

[ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

Name

Date

Nature of Relationship

Do you have children? [ ] Yes [ ] No

If yes, complete the following:

First Name Age Gender

Nature of Relationship

Are there presently any child custody issues involving you or your family?

[ ] Yes [ ] No

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes [ ] No

If you answered yes, please elaborate including substance, duration, and treatment history

Additional Information

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

______________________________ ______________________________

Signature of client Date