James A. Davidson
OneHeartTLC Counseling Center

The following form, which will become part of your confidential record, will enable me to gain an understanding of who you are and why you are seeking counseling at this time.

Name: DOB: _____/_____/_____

Age: _____ ☐ M ☐ F SSN:_____-____-_____ Ethnicity (optional):_____

Address: _____
Street City State/Zip

Preferred Phone:_____ Alt Phone (specify):_____

Cell phone & carrier:_____Email:_____

PLEASE CIRCLE:

1. It is ok to receive mail at this address: ☐YES ☐NO
2. It is ok to leave voicemail on my preferred phone: ☐YES ☐NO
3. It is ok to send email to the above address: ☐YES ☐NO

Marital Status: ☐ Single ☐ Committed Relationship ☐ Married ☐ Divorced

Partner's Name: _____ How long have you been together? _____

Child's Name	Age

Child's Name (cont.)	Age

Insurance Information:

Carrier: Group # **Member ID:_____**
Phone number from back of card for BH/MH services: _____

If TRICARE, Sponsor ID:

Family

Please list significant relationships with your family (mother, father, siblings, grandparents, etc.)

Name	Relationship to you	Age	Alive/Passed (if passed, when?)

Briefly describe your reason for seeking therapy:

_____
_____
_____
_____

Have you been to therapy for this issue before? ☐ YES ☐ NO

If yes, what did you like/find helpful about the process:

Medical History

Please describe any current or chronic medical conditions:

Please indicate any concerns /changes with the following in last 6 months:

☐ Sleep (not enough/too much)	☐ Appetite (loss/gain more than 10lbs in 30 days)
☐ Anxiety	☐ High Bood Pressure
☐ Racing thoughts	☐ Diabetes
☐ Difficulty Concentrating	☐ Blood Clots
☐ Rage/anger	☐ STD
☐ Sadness/Depression	☐ Pregnancy
☐ Significant stress	☐ Feel suicidal
☐ Paranoia/suspicion of people	☐ Chronic Pain
☐ Loss of interest in activities	☐ Substance abuse/dependency
☐ Loss of productivity at work	☐ Binge eating and/or purging
☐ Frequent crying spells	☐ Other health condition: _____

In the last 30 days, how many times have you been late or missed work due to these issues: ☐ Never ☐1-2 Times ☐More than 3 times

In the last 30 days, how have these issues impacted your relationships with family and friends: ☐ Never ☐1-2 Times ☐More than 3 times

In the last 30 days have you felt suicidal or felt like harming yourself: ☐ YES ☐ NO

In the past 30 days have you felt like harming someone else: ☐ YES ☐ NO

Primary Care Physician: Name:_____ ph:_____

Prescribing physician (if different): _____ph: _____

CURRENT MEDICATIONS:

Medication	Dosage	Taken as prescribed?

Have you taken any medications for anxiety, depression, bipolar disorder or ADHD that have NOT worked? _____

Substance Use:

Alcohol : ☐ YES ☐ NO If yes, amount weekly:

Marijuana: ☐ YES ☐ NO If yes, amount weekly:

Other controlled substances: ☐ YES ☐ NO Specify:__ Amt weekly:

Are you in recovery? ☐ YES ☐ NO

If YES, do you have a sponsor? ☐ YES ☐ NO
How long have you been in recovery? _____