SunSet Community Counseling

Date: _____ Phone: _____

Name: _____ Birthdate: _____

Address: _____ Emergency Contact Phone Number/Relationship:

_____ _____

Is it ok to leave a message? ___Yes ___No
Is it ok to use texting for appointment/scheduling/confirmations? ___Yes ___No

What are your main concerns at this time?_____

_____

Have you been in counseling/therapy before? ___No ___Yes: Was it helpful? _____

Do you or any members of your family have a history of alcoholism, chemical dependency, epilepsy, depression or suicide? Please circle all that apply.

What else might be considered a mental health concern? _____

Have you recently had thoughts of suicide? ___Yes ___No
Have you ever attempted to die by suicide? ___Yes ___No

CURRENT SYMPTOMS:
Behaviors – Circle any of the following behaviors that apply to you:

Work too hard	Compulsions	Risk taking	Poor Concentration
Withdrawal	Sexual problems	Relationship problems	Loneliness
Eating problems	Procrastination	Sleep disturbance	Aggressive behavior
Impulsive reactions	Hopelessness	Crying	Diminished self-esteem
Excessive worry	Phobic avoidance	Alcohol/Substance use	Outbursts of temper
Loss of control	Restlessness	Recurring dreams/thoughts	Stress—from_____

Are you taking any medication for these symptoms? _____

Who is the prescribing physician? _____

Do you practice relaxation regularly? _____ How? _____

What type and how often do you get regular physical exercise? _____

Client Signature _____ Date_____