PATRICIA E. CONE, MA, LCMHC

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Confidential Personal Information

(if under 18, parent must complete separate form)

Name_____ Date_____

Phone_____ Cell_____

Address_____ City_____ Zip_____

Date of birth_____ Age_____ Referred by_____

Occupation_____ Total hours/week_____

Employed by_____ Phone_____

E-mail_____ Church_____

Name of Spouse_____ Date of Birth_____ Age_____ Occupation_____

Number of years Single_____ Married_____ Widowed_____ Separated_____ Divorced_____

Please describe why you are coming to counseling (i.e., what are your issues, problems?)_____

_____

_____

What do you hope to gain from this counseling experience?_____

_____

If you have had any previous counseling, psychiatric treatment, or residential/in-patient care, please list the dates, duration and names of therapist or programs (use back of sheet if necessary)_____

_____

_____

In case of emergency, please contact_____ Phone_____

If you will be seeking reimbursement from your insurance company, please complete and sign below.

I authorize Patricia E. Cone Counseling Office to release clinical information requested by my insurance company:_____ to process my insurance claims.

Policy #_____ Group #_____

Name of Ins. Subscriber (if not client)_____ Subscriber's Date of Birth_____

Sign_____ Date_____

Health Information

Describe any physical problem you have that requires medication or physical care:_____

_____

Are you currently receiving medical treatment? Yes_____ No_____

Are you currently taking any prescription drugs? Yes_____ No_____ If yes, please list each drug with the daily dosage_____

_____

Please check any of the following physiological symptoms/sensation that apply to you currently, or in the recent past:

____ Headaches	____Rapid heart rate	____Dizziness	____Difficulty breathing
____Stomach trouble	____Intestinal trouble	____Visual trouble	____Hearing noise/voices
____Trouble with sleep	____Change in appetite	____Trouble relaxing	____Pain-Specify_____
____Weakness	____Tiredness	____Tension	____Other_____

What is your height?_____ What is your weight?_____

How has your weight changed in the past 2-3 months?_____

CURRENT STATUS – Please put "s" for self or "o" for others in your family to any of the following problems that apply:

____Stress	____Nervousness	____Anxiety	____Panic
____Unhappiness	____Depression	____Guilt	____Apathy
____Terminal illness	____Recent death in family	____Grief	____Hopelessness
____Inferiority feelings	____Defectiveness feelings	____Loneliness	____Shyness
____Fears	____Friends	____Marriage	____Communication problems
____Physical abuse	____Emotional abuse	____Verbal abuse	____Sexual abuse
____Temper	____Anger	____Aggressive behavior	____Bad dreams
____Concentration	____Racing thoughts	____Unwanted thoughts	____Memory
____Loss of control	____Impulsive behavior	____Self control	____Compulsivity
____Sexual problems	____Pregnancy	____Abortion	____Legal matters
____Trauma/disaster	____Eating problems	____Drug use	____Alcohol use
____Trouble with job	____Career choices	____Ambition	____Making decisions
____Children	____Being a parent	____Finances	____Other

Please indicate on the scale below how distressing your problem(s) are to you. Place an X on the line.

Distresses Very Little Neutral Extremely distressed

_____

Are you currently experiencing any suicidal thoughts? _____Yes _____No

Have you experienced suicidal thoughts or attempted suicide in the past? _____Yes _____No

Have any of your friends or family ever committed or attempted suicide? _____Yes _____No