

WELCOME TO CROSSROADS COUNSELING ASSOCIATES

Thank you for selecting Crossroads Counseling Associates. We will strive to provide you with the best possible care. To help meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. All information which you provide us is strictly confidential.

Date _____ Referred by _____

Client name _____ DOB _____

Address _____

	City	Zipcode
Cell phone _____	Ok to leave message Y	N

Home phone _____	Ok to leave message Y	N
------------------	-----------------------	---

Work phone _____	Ok to leave message Y	N
------------------	-----------------------	---

Email address _____	Ok to send message Y	N
---------------------	----------------------	---

Employer & Address _____

Gender M F Religious Affiliation _____

Marital Status (circle the applicable answer) How Long: _____

Single Engaged Married Remarried Separated Divorced Widowed

Spouse's name _____ DOB _____

(or Parent's Name, if minor)
Home phone _____ Ok to leave message Y N

Work phone _____ Ok to leave message Y N

Spouse's/Parent's Employer & Address _____

Emergency Contact: _____

Their Daytime Phone () _____ Evening phone () _____

Current Physician and phone # _____

Current medications _____

List all previous therapist and counseling experience _____

Have you formally terminated therapy with your previous therapist? Yes No N/A

If yes, are you willing to sign a release of information? Yes No

Do you have insurance that you want to use for billing? (if yes, include name, and bring card to first session) _____

Family History: Health	Age or	Date of	Has anyone in your family experienced any of the following: (Check any which are appropriate)
Death			<input type="checkbox"/> schizophrenia
Natural Mother	_____	_____	<input type="checkbox"/> depression
Natural Father	_____	_____	<input type="checkbox"/> mood swings
Step-Mother	_____	_____	<input type="checkbox"/> anxiety/panic attacks
Step-Father	_____	_____	<input type="checkbox"/> suicide or attempts
Siblings (sisters, brothers)			<input type="checkbox"/> sexual abuse
_____	_____	_____	<input type="checkbox"/> physical abuse
_____	_____	_____	<input type="checkbox"/> alcohol abuse
_____	_____	_____	<input type="checkbox"/> drug abuse
Children:			<input type="checkbox"/> imprisonment
_____	_____	_____	<input type="checkbox"/> learning disability
_____	_____	_____	<input type="checkbox"/> attention deficit
_____	_____	_____	<input type="checkbox"/> mental retardation
_____	_____	_____	<input type="checkbox"/> dementia/brain damage

Symptom & problem list:

Please respond to each item (Y or N)

- | | | |
|---|---|--|
| <input type="checkbox"/> No energy | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Cannot enjoy life | <input type="checkbox"/> Disturbing memories | <input type="checkbox"/> Guilt feelings |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Anger outbursts | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unwanted thoughts |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Racing heart |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Clammy hands | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Startles easily | <input type="checkbox"/> Sleeps too much |
| <input type="checkbox"/> Relives past event | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Always on guard |
| <input type="checkbox"/> No love feelings | <input type="checkbox"/> Hopeless feelings | <input type="checkbox"/> Apathetic |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Numbing out |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Distrustful |
| <input type="checkbox"/> Decisions difficult | <input type="checkbox"/> Overly confident | <input type="checkbox"/> Pressured speech |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Buying sprees |
| <input type="checkbox"/> Foolish business investments | <input type="checkbox"/> Sexual indiscretions | <input type="checkbox"/> High risk activities |
| <input type="checkbox"/> Hard to make friends | <input type="checkbox"/> Socially withdrawn | <input type="checkbox"/> Family arguments |
| <input type="checkbox"/> Work problems | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Often physically sick |
| <input type="checkbox"/> Out of control behavior | <input type="checkbox"/> Drinking alcohol | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Take pain killers often | <input type="checkbox"/> Seeing things | <input type="checkbox"/> Loosing tract of time |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Excess energy | <input type="checkbox"/> Slowed thinking |
| <input type="checkbox"/> Unusual experiences | <input type="checkbox"/> Unsure of reality | <input type="checkbox"/> Physical violence |
| <input type="checkbox"/> Physical numbness | <input type="checkbox"/> Wish to die | <input type="checkbox"/> Unsure of identity |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Confusion | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weight change | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sporadic dieting |
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Blackouts/fainting |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hallucinations |

Briefly describe why you have come: _____