

**Diakonos, Counseling
General Patient Information**

Date: _____

Patient Name: _____ SSN: ____-____-____

Date of Birth: ____ / ____ / ____ Gender: Male Female Ethnicity _____

Home Address: _____
Street

_____ City State Zip

Home Phone Number _____ May we leave a message? Yes No

Work Phone Number _____ May we leave a message? Yes No

Mobile Phone Number _____ May we leave a message? Yes No

If the above patient is a minor complete the following:

Name of Guardian: _____

Address of Guardian: _____
Street

_____ City State Zip

Guardian's Home Phone _____ May we leave a message? Yes No

Guardian's Work Phone _____ May we leave a message? Yes No

Guardian's Mobile Phone _____ May we leave a message? Yes No

If you will be using insurance to cover a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

Primary Insurance Company: _____

Secondary Insurance Company if applicable: _____

Referral Source

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

Emergency Contact Information

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone Number: _____

Previous Treatment

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

Additional Information: _____

Have you had hospital stays for psychological concerns? Yes No

Additional Information: _____

List any current, or important past, medications

Medication & Dose	Date	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Have you in the past experienced thoughts of harming either yourself or some one else? Yes No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? Yes No

If yes, explain: _____

Did you walk, talk, and read on time? Yes No, explain: _____

Medical History

History of serious childhood illnesses : _____

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

Have you experienced any head injuries? Yes No Important Details: _____

If yes, did you lose consciousness? Yes No

Have you experienced convulsions or seizures? Yes No If yes, did you also have a fever? Yes No

Explain any allergies you have: _____

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

Family History

Birth Location _____ Raised by: Mother Father Step-Mother Step-Father
 Other: _____

Relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: _____
Father: _____
Other: _____
Other: _____

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

Any Additional Family Information: _____

Social History

Describe your relationship with peers and/or friends.? _____

How would you describe your social support network? _____

Describe your hobbies/interests: _____

Have you ever had concerns about being too "shy" or "timid"; or too "rambunctious" or "loud" socially? _____

Describe any cultural concerns: _____

What is your religious/spiritual background? _____

Do you wish to integrate religious/spiritual material as part of treatment? Yes No

Educational History

When attending school where you : In regular classes
 Home Study
 Special classes: _____
 Ever suspended: _____

What is the highest educational level you have completed? _____

Give any additional important educational information (i.e. Did you like school?): _____

Occupational History

What is your current employment status? Employed Full-Time Employed Part-time Unemployed
 Self-employed Student

If employed, who is your employer? _____ What is your position: _____

How would you describe your job satisfaction: Poor Fair Good Great

How would you describe your job performance: Poor Fair Good Great

What type of employment or training have you had previous to your current occupation? _____

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:

First Name	Dates	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 Additional Information: _____

Legal & Military History

Are you presently, or have you previously served in the military? Yes No If yes complete the following:

Do you currently have any pending criminal charges? Yes No

Have you ever been convicted of a crime? Yes No: If yes explain: _____

Does your family currently have Division of Family Services Involvement? Yes No

If yes please complete the following:

DFS Case Worker's Name : _____ Phone: _____

Additional Information

Summarize your goals for counseling/therapy: _____

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

Signature of patient or guardian

Date

Your signature below indicates that you have received this agreement (PDS) and agree to its terms. It also serves as an acknowledgement that you have received the HIPAA notice form described above. Failure to honor these policies may lead to termination of our work together and/or referral.

Printed Name

Signature

Date