First Name:_____ MI:_____ Last: _____

Birth date:_____/_____/_____ Current Age: _____ Last four SS #: _____
Month Day Year

SECTION A: **CLIENT INFORMATION**

PREFERRED NAME: _____ **GENDER IDENTITY/SEXUAL ORIENTATION:** _____

ETHNICITY: ☐ African American ☐ American Indian/Eskimo ☐ Asian American ☐ Caucasian ☐ Hispanic ☐ Mexican American
☐ Multi-Ethnic ☐ Native Hawaiian/Pacific Islander ☐ Puerto Rican ☐ Other _____
☐ International (list your country):_____

RELATIONSHIP STATUS:

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other (specify):

CONTACT INFORMATION (check all that apply):

Cell Phone #:_____ ☐ OK to phone ☐ OK to leave message
Home or other Phone #:_____ ☐ OK to phone ☐ OK to leave message

Email address: _____
Your email address will be used to remind you of upcoming appointments and/or for invoices

ACADEMIC LEVEL**:**

☐ No HS Diploma ☐ HS Diploma/ GED ☐ Associates ☐ Bachelors ☐ Graduate
☐ Other _____

EMPLOYMENT **INFORMATION:**

☐ Employed Part-time ☐ Employed Full-time ☐ Not Currently Employed

REFERRED BY: (check all that apply)

☐ Self ☐ Friend ☐ Parent ☐ Spouse/Partner
☐ Medical Provider ☐ Other (specify) _____

RELIGION/CULTURAL PREFERENCES:

SECTION B: PRESENTING CONCERNS

Briefly describe what brings you to Evolve Counseling & Consulting**:**

During the past year, what kind of stressors have you had?:

Approximately how long has this concern been bothering you?

☐ Day ☐ Week ☐ Month ☐ Several months ☐ Year ☐ Several years ☐ Most of my life

Approximately how many counseling sessions do you think you will need?

☐ 1-3 sessions ☐ 4-6 sessions ☐ 7-9 sessions ☐ 10+

SECTION C: MENTAL HEALTH HISTORY

Have you received counseling or psychotherapy in the past (check all that apply):

☐ Never ☐ As a child ☐ As a teen ☐ As and adult

Previous therapist(s)/treatment facility(s):

Have you ever participated in group therapy? ☐ Yes (specify below) ☐ No

If YES, where, and what was the focus of the group(s):

Have you purposely injured yourself without suicidal intent? (e.g., cutting, hitting, burning, etc.) ☐ Yes ☐ No

If YES, please explain:

Have you made a suicide attempt? ☐ Yes (specify below) ☐ No

If YES, please describe when and the nature of the attempt:

☐ ☐

Do you consider your alcohol consumption or drug use a problem? ☐ Yes ☐ No ☐ Not Applicable

SECTION D: FAMILY

Family Information: Complete for all members of your family, **including yourself**. Circle your own rank among the siblings (1st, 2nd, 3rd, etc.)

	Relationship	Marital Status	Living or Deceased	Age	Sex	Occupation	Education
Family Of Origin	Parent 1						
	Parent 2						
	Parent 3						
	Parent 4						
	1st Sibling						
	2nd Sibling						
	3rd Sibling						
	4th Sibling						
Others living in Family Home							
Current Family	Spouse/Partner						
	1st Child						
	2nd Child						

SECTION E: MEDICAL HISTORY

Do you have any medical condition s for which you are currently being treated, if so please describe:

Please list any previous medical conditions:

Are you currently taking any prescribed medications: ☐ Yes (specify below) No

Name:	**Dosage:**	**Diagnosis:**
Name:	**Dosage:**	**Diagnosis:**
Name:	**Dosage:**	**Diagnosis:**