KATE HEITZLER
Counseling & Consultation

CLIENT INFORMATION

Today's Date: _____

Name: _____Birthdate: _____Age:_____ Gender: M F

Address: _____ Zip: _____

Email Address: _____

Telephone: (H) _____(C) _____ (W) _____

Ok to Leave Voicemail? YES NO

How did you hear about Kate Heitzler Counseling & Consultation, LLC?

_____

Emergency Contact: _____Phone: _____

Current Situation: Briefly describe the issue that prompted you to seek counseling at this time:

_____

_____

Are there other people who play a major role in causing or in helping you cope with problems? Yes_____ No_____

Explain:

_____

List three goals you hope to reach through counseling.

_____

_____

_____

Is there anything else that you believe might be important for your counselor to know at this time?

_____

Counseling History:

Have you had previous counseling/therapy? Yes _____ No_____

With Whom? (Name/ City) _____

If yes, when?_____ For how long? _____ For what condition: _____

Have you ever been hospitalized for a psychiatric condition? Yes_____ No_____

If yes, please describe briefly:

_____

What are your current supports and resources?

_____

_____

Marital/ Family Status (Check One):

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

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Relationship Satisfaction: 1 2 3 4 5 6 7

Spouse's Name: _____ How long have you been married? _____

Previous marriages? _____ When/ for how long? _____

Reason for divorce? _____

Children's Names:	Ages:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Background:

Father's Name: _____Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school:_____Occupation _____

Any medical, psychiatric or substance abuse problems that you know of?

_____

Quality of relationship currently?

_____

Quality of relationship during childhood?

_____

Mother's Name: _____Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school: _____Occupation _____

Any medical, psychiatric or substance abuse problems that you know of?

_____

Quality of relationship currently?

_____

Quality of relationship during childhood?

_____

Number of Siblings:_____

Other noteworthy childhood relationships? Explain:

_____

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Significant childhood events (divorce, deaths, abuse, sickness, traumas, moving etc.)

_____

_____

Education:

Years of education completed: _____Degrees received:_____

Specialized training or trade school: _____

Do you have any learning or developmental disabilities? Please specify: _____

_____

Do you have any background/experiences in the military? ____ Describe briefly _____

_____

Occupation:

Primary place of work: _____ Position:_____

How long have you worked there? _____ Describe the nature of your work: _____

_____

Do you find this work satisfying? _____ Number of hours work per week: _____

Medical History:

Describe any physical problems that require medication or physical care: _____

_____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult your primary care physician? _____
Who is your primary care physician? (Name/Address) _____
Other physicians whose care you regularly receive: _____
Are you currently taking any prescription medication? Yes_____ No_____

Medical History (continued): Please list your medications here:

Name:	Dosage:	For what condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug/Alcohol History:

Do you consume any caffeine? YES NO Description/Frequency: _____

Do you consume alcohol? YES NO Description/Frequency: _____

Do you use recreational drugs? YES N) Description/Frequency: _____

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Have you had any problem in the following areas related to your use of alcohol or drugs? If so, please mark:

Family _____ Friends/social: _____ Employment: _____ Financial: _____ Health: _____ Legal: _____

Other: _____

Describe your view of your substance use:

Not a problem _____ Becoming a problem _____ A severe problem _____ Family thinks its a problem_____

DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	Now	PAST
Anxiety			Finances		
People in General			Sexual Concerns		
Depression			Memory		
Parents			Child abuse		
Children			Racing Thoughts		
Anger or Temper			Trusting Others		
Employer			Emotional Abuse		
Sexual Abuse			Thoughts of hurting self		
Mood Changes			Abusive Relationship		
Communication			Careless with Others		
Drugs			Alcohol		
Sex			Thoughts of Suicice		
Suicide Attempts			Self Harm		
Speaking without thinking			Blackouts		
Dissociation			Sleeping to much		
Completing tasks			Eating Problems		
Self Worth			Self Esteem		
Self Image			Self Confidence		
Paying attention			Severe Weight gain		
Weight Loss					

FAMILY HISTORY OF		FFAMILY HISTORY	
Anxiety		Finances	
Drugs		Alcohol	
Depression		Legal Trouble	
Sexual Abuse		Emotional Abuse	
Physical Abuse		Child Abuse	
Anxiety		Domestic Violence	
Psychiatric Hospitalization		Suicide	
Mental Illness		Nevous Breakdown	
Abandonment		Divorce	