

GREEN WAVE FAMILY WELLNESS CENTER

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ADULT/COUPLE/FAMILY CLIENT INFORMATION FORM

(**Each Adult fills out their own**)

****This professional relationship does not begin until the Intake session where the forms are then reviewed, agreed upon, and the consent form is signed by the therapist and those involved. If this is an emergency prior to the initial session, please contact 911.**

Name: _____ Date of Birth: ___/___/___ Intake Date: ___/___/___
SSN: _____ Who referred you to this office? _____
Email Address _____
Address: _____ Home Phone (____) _____
_____ Cell Phone (____) _____
_____ Partner's Cell (____) _____
Occupation/School: _____ Employer: _____
Current/Completed Education Level _____ Phone #: _____
Hobbies/Clubs: _____ Is Leaving Messages on personal numbers
_____ if needed okay? _____

INSURANCE INFORMATION

Insurance Co: _____ Policy #: _____
Are you the policy holder? Yes or No Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ and Policy Holder's SSN _____

FAMILY INFORMATION

Marital Status: _____ # of times Married _____ Total # years in current relationship _____
(Married--Divorced--Single-Dating)
Significant Other's Name: _____ Date of Birth: ___/___/___
Willingness to join counseling (Yes--No--Maybe) Home Phone (____) _____
Partner's Employer _____ Work Phone (____) _____
Parent/Guardian _____ Home Phone (____) _____
Willingness to join counseling (Yes--No--Maybe) Employer _____ Work Phone (____) _____
Other Members in Home:
Name and Relation: _____ Gender _____ Age _____
Name and Relation: _____ Gender _____ Age _____
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Name and Relation: _____ Gender _____ Age _____
Emergency Contact: Name: _____ Relationship _____
Address: _____ Phone (____) _____

Please provide a brief explanation of the events or issues that led to the need to seek counseling services:

Client Name: _____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

- Fighting
- Disagreeing about relatives
- Feeling distant
- Disagreeing about friends
- Loss of fun
- Alcohol or Drug use
- Lack of honesty
- Trauma
- Medical Concerns
- Infidelity (couple)
- Education problems
- Divorce/separation
- Financial problems
- Issues regarding remarriage
- Death of a family member
- Birth of a child
- Inadequate health insurance
- Job changes or job dissatisfaction
- Inadequate housing/feeling unsafe
- Other _____

PERSONAL HISTORY

List your medical history/health problems (Include eating, sleeping, head/stomach aches, hives & stress patterns).

Are you currently seeing any medical/counseling professionals? If so, who and for what reason? _____

Are you on any medications and if so, what and for what reason? _____

Is there any history of mental illness or suicide in your family? _____

Is there any history/current abuse? Physical _____ Sexual _____ Emotional _____ Neglect _____

IF so, by whom, on whom, when, how, and where? _____

Describe any military history _____

Client Name: _____

ALCOHOL AND DRUG USE

How would you describe your use of alcohol or drugs? (Circle one) Never used, Use, Misuse, Abuse

If you have used drugs or alcohol, what types, for what reasons, with whom, when, and how often? _____

Please describe what history of drug or alcohol problems that may exist in your family or close relationships?

CLIENT'S DATING/MARITAL HISTORY

Where did you receive your sex education? _____

How long did your last three relationship last? _____

What were the reasons your previous relationship terminated? _____

What was courtship like with the current or last significant relationship? _____

What were the reasons (characteristics, personal thoughts, and common goals) that led to the marriage/relationship?

Circle the level of Satisfaction in current relationship Very High---- High--Medium--Low--Very Low

Circle the level of Stability in current relationship Very Stable---Stable--Fairly Stable-- Unstable--Separated

List the satisfactions in current relationship _____

List the dissatisfactions in current relationship _____

Does your Significant other or Parent (s) like your friends? _____ How would they describe the people with which you spend most of your time. _____

If your significant other's or guardian's were fussing at you what would they be fussing about? _____

Who is your best friend and what would I see you and your best friend most often doing together?

Client Name: _____

EDUCATIONAL HISTORY

What was your last/current level of education? _____

If in school, what kind of grades do you make? If only in work, how would you grade your work performance?
(A's) (A's & B's) (B's) (B's & C's) (C's) (C's & D's) (D's) (D's & F's) (F's)

How is/was your School and/or work attendance? School _____ Work _____

How would your teachers/employers describe you? _____

Do you have any disciplinary troubles or peer difficulties (fights, ridicule, relationship difficulty) if so, what?

Do you have a juvenile or adult criminal record? _____ List any charges and dates: _____

What are some skills you see yourself as having that are positive? (Computer, Job Skills communication, art, musical instrument....) _____

What do you see yourself doing (goals) in?
Short term (1 year) _____
Mid term (3 years) _____
Long term (10 years) _____

Have there been any significant changes or events in the past 9 months (deaths, moves, crisis, changes in relationships, job, income, school.) _____

List any significant changes or events expected within the next year? _____

Describe a typical day (school, work, social, religious, and other activities). _____

Are any of the following a challenge to you: culture, ethnicity, religion, lifestyle, age, physical challenges?

If you had a problem, who would you most likely talk to? _____

Client Name: _____

CURRENT PROBLEM IMPACT

On a scale of 1-10, how much does this problem that brought you in interfere with your everyday living?

1 = little.....10 = greatly _____

Are you or have you been suicidal? ___ Yes ___ No

Have you ever used self-harm Yes ___ (current or past) No ___?

What thoughts, feelings, and behaviors are associated with your problem? _____

How does the problem interfere with your everyday living? _____

Do you have any physical stress related complaints? _____

When did this problem that brought you in first appear? _____

How often does the problem affect your life? _____

Do you notice any patterns (people, places, or events/before, during or after) that surround the problem? _____

What actions have you taken to deal with the problem? _____

What strengths do you have that have helped you deal with the problem? _____

Who is on your side that is or could be helpful with this struggle you are facing? _____

What caused you to seek counseling at this time? _____

If you have had experiences with counselors/counseling in the past, what was helpful and what was not helpful?
