Please save the completed form and email it to frontdesk@panamacitywellness.com

GREEN WAVE FAMILY WELLNESS CENTER
625 Jenks Avenue Panama City, FL 32401
PanamaCityWellness.Com
Ph. 850-215-5657 Fax: 850-215-5658

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: _____
_____
_____
Occupation/School: _____
Current/Completed Education Level _____
Hobbies/Clubs: _____
_____

Home Phone (____) _____
Cell Phone (____) _____
Partner's Cell (____) _____
Employer: _____
Phone #: _____
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_____
Name and Relation: _____ Gender_____Age_____
Name and Relation: _____ Gender_____Age_____
Name and Relation: _____ Gender_____Age_____
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
__Feeling distant
__Loss of fun
__Lack of honesty
__Medical Concerns
__Education problems
__Financial problems
__Death of a family member
__Inadequate health insurance
__Inadequate housing/feeling unsafe
__Other_____
__Disagreeing about relatives
__Disagreeing about friends
__Alcohol or Drug use
__Trauma
__Infidelity (couple)
__Divorce/separation
__Issues regarding remarriage
__Birth of a child
__Job changes or job dissatisfaction

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?

_____

_____

_____