Confidentiality Notice: Federal & State regulations requires that all information contained in this document be treated CONFIDENTIAL.

Counseling & Disability Services, LLC
1635 S. Ridgewood Ave., Suite 225
South Daytona, Florida 32119

Client Name: _____ Today's Date: ____/____/____
Last First Middle
Date of Birth: ____/____/____ SS#: _____

Sex: ☐ Male ☐ Female Sex: ☐ Bi-Racial ☐ Black ☐ Hispanic ☐ White ☐ Other

If client is a minor, print name of parent/guardian: _____

Mailing Address: _____

_____

Home Phone #: (____)_____-_____ Mobil Phone #: (____)_____-_____

OK to contact at home or leave a message? ☐ Yes ☐ No What hours?: _____

# of people in the household: _____ Email: _____

First Name	Last Name	Age	Sex	Relationship

Please check the family structure that best describes your home:

☐ Biological family ☐ Step-parent family ☐ Single Parent family ☐ Other (specify): _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

Employer/School: _____ Occupation: _____
Work Phone #: (____)_____-_____ OK to contact at work? ☐ Yes ☐ NO When? _____

Person to be contacted in case of emergency: _____ Phone #: (____)_____-_____
Have you, or any member of your family, ever been in counseling? _____
If yes, type of program and where? _____
Who referred you? _____

INSURANCE INFORMATION: PLEASE COPY CARD FRONT & BACK

Are you currently involved with court? ☐ Yes ☐ NO Have you been in the past? ☐ Yes ☐ No
If yes, please provide the documents as soon as possible.

Do you have any handicap conditions which would require special arrangements? ☐ Yes ☐ No
Primary Care Physician: _____ Phone #: (____)_____-_____
Psychiatrist: _____ Phone #: (____)_____-_____

PRESENT PROBLEM(S)
Please describe your reasons for seeking counseling (include date/month problem started):

_____

_____

_____

Was there an event which made these issues or problems surface? ☐ Yes ☐ NO If yes, describe:

_____

_____

_____

PSYCHIATRIC HISTORY
Have you ever received psychiatric or psychological treatment of any kind before? ☐ Yes ☐ No
If you checked yes to the above question, please answer the following:
What type of treatment did you receive? ☐ Inpatient (hospital) ☐ Outpatient ☐ Both
When were you in treatment? _____
Where? _____
For how long? _____
Name of therapist/doctor you work with? _____
Did you receive medication? ☐ Yes ☐ NO ☐ Not Applicable
Is any other family member on medication? _____

MEDICAL HISTORY

Please list any prescription or over-the-counter medications you currently use (Name, Dosage, Frequency): _____

_____

List your physical symptoms and illnesses _____

_____

Please list any past or present medical conditions: _____

_____

FAMILY HISTORY

List any medical or psychiatric conditions of your parents and siblings:

_____

_____

HABITS	AMOUNT CURRENTLY USING PER DAY	MOST EVER USED
Coffee, tea	_____	_____
Cigarettes (packs per day)	_____	_____
Alcohol	_____	_____
Marijuana	_____	_____
Cocaine	_____	_____
Other Drugs	_____	_____

Have you ever felt you ought to cut down on your drinking? _____
Have people annoyed you by criticizing your drinking? _____
Have you ever had a drink the first thing in the morning to
Steady your nerves or get rid of a hangover? _____

SOCIAL/CULTURAL/SPIRITUAL

What are your religious or spiritual beliefs? _____
How important are they to you? _____
Is religion/spirituality a source of support for you? ☐ Yes ☐ NO
How much? Low 2 3 4 5 6 7 8 9 High (Circle One)

My cultural identity is: ☐ Very Important ☐ Important ☐ Not Important

Do you have any preferences/special concerns relating to your religious beliefs/ethnic identity that we need to consider in planning your services? ☐ Yes ☐ NO If yes, explain:

_____

_____

Client Name: _____ Date: _____

TO BE COMPLETED BY THE CLIENT OR PARENT/GUARDIAN IF CLIENT IS YOUNGER THAT 18 YEARS OLD.

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