CUMBERLAND VALLEY COUNSELING ASSOCIATES

INITIAL CONTACT FORM

NAME: ______________________________ **Birth Date:** __________ **Date:** __________

ADDRESS: ____
Street Town State Zip

CIRCLE PREFERRED METHOD OF CONTACT

TELEPHONE: ____
Home Work Cell

EMAIL ADDRESS: ____

REASON WHY YOU CALLED: ____

EMERGENCY CONTACT PERSON: ____
Name Relationship Telephone Number

INSURANCE:

Primary: ____
Insurance Company Policy Holder or Relation to Holder ID Number

Secondary: ____
Insurance Company Policy Holder or Relation to Holder ID Number

Primary Insured ____
Name Date of Birth SSN#

EMPLOYER OF POLICY HOLDER: ____

How did you hear about our company? : _______________________________

____

Modified: December 3, 2008; June 23, 2010; October 9, 2013; August 2014, Oc 2016

NAME: ____ Birth Date: ______________ Date: ________________

ADDRESS: ____
Street Town State Zip

TELEPHONE: ____
Home Work Cell

GENDER: _____________________ SEXUAL ORIENTATION: ___________________________

CURRENT RELATIONSHIP STATUS: _____ In Relationship _____ Single _____ Married ______ Divorced
_____ Separated _____ Widowed/When: __________________

CURRENT RELATIONSHIP: Years: _________ Number of Long Term Relationships/Marriages ______
Describe current relationship:

____

CHILDREN/HOUSEHOLD MEMBERS: Name(s), Ages Describe how do you get along with each one.

___________________________________ ____

___________________________________ ____

___________________________________ ____

RECENT CHANGES IN YOUR FAMILY: DESCRIBE: ____

FAMILY OF ORIGIN

	Ages	How do you get along with each?	Any mental health or drug/alcohol problems?
MOTHER:			
STEPMOTHER:			
FATHER:			
STEPFATHER:			
BROTHER:			
BROTHER:			
BROTHER:			
SISTER:			
SISTER:			
SISTER:			

MARITAL STATUS OF PARENTS: _____ In Relationship _____Married _______ Divorced/when: __________
Widowed/when: ___________

YOU ARE ______________ IN ORDER OF AGE: first, second, third, etc

LOSSES: Were you close to anyone who died or was killed? Describe who, when and what happened:

____

____

ABUSE HISTORY: Have you ever experienced abuse – physical, verbal, mental, emotional, sexual? _____ No
_____ Yes: Describe if you are comfortable: when, by whom, what happened: ______________________________

____

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CLIENT HISTORIES

NAME: ___________________________________ ID# __________________________Date: ____________________

EDUCATION/TRAINING:

Highest Level of Education: _____ High School _____ College _____ Graduate
_____ Other Training/Certificates: ____

EMPLOYMENT HISTORY:

Are you currently employed? _____ No ____Yes:
If "Yes", employer is: ____________________________ How long have you worked here? ______ Years
What do you do? ____
Do you enjoy your work? _____ No _____ Yes Why do you like or dislike your work? ____________________
____
How many jobs have you had in the last: three years _____ five years _____ ten years _______

PAST PSYCHOLOGICAL/PSYCHIATRIC HISTORY-OUTPATIENT OR IN HOSPITAL:

Dates	Hospital/Agency	Problem	Helpful or Not

FOOD ISSUES: **____ binging ____ vomiting ____compulsive/overeating _____ overuse of laxatives**
_____ diuretic abuse _____ not eating _____ Other: Describe: ________________________________

ADDICTIVE ISSUES: **____ gambling ____ exercise ____ pornography ____ internet ____ sex ____ hair pulling**
____ skin picking ____ shoplifting/stealing _____ compulsive (perfection): describe: ____________________

CIGARETTE/SMOKING HISTORY: **Do you smoke/chew now? ____ Yes ___ No If "YES": How much daily? _____**
How many years? _______ Did you smoke/chew in past? ____ Yes ___ No If "YES": How many years? _____

ALCOHOL HISTORY: **Do you use alcohol now? ____ Yes ___ No If "YES": How much weekly? ____________**
How many years? _______ Did you use alcohol in past but not now? ____ Yes ___ No If "YES": Years? _____
Is alcohol a problem in your life? _____ No _____ Yes: describe: ________________________________
DUI: ___ No ___ Yes If "Yes", how many? ________ Date of last DUI:
____

DRUG USE: EXCLUDING PRESCRIBED MEDICATION:

Do you use drugs now? ____ Yes ____ No If "YES": Describe what: ________________________________
How much weekly? ____ How many years? ________
Did you use drugs in the past but not now? ____ No ___ Yes If "YES", describe what: ____________________
________________ Amount used in week: ________________________ How many years used? ______________
Are drugs a problem in your life? _____ No _____ Yes: describe: ________________________________

SOCIAL HISTORY: **Describe yourself: ____**

____

What do you like about yourself:
____?

____

Where does your strength come from? Example: Spirituality, Inner Strength, Own Values, Family, etc.

____

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CLIENT HISTORIES

NAME: ______________________________ ID# ________________________ Date: ______________

How do you see the world/others? ____

What would you like to change in your life? ____

Circle one
I have close friends/close family members: none a few some many a lot
For enjoyment, I ____

Describe your social, recreational, exercise activities: ________________________________

MEDICAL HISTORY:

PHYSICIAN NAME: ______________________ Group: _____________ Telephone: _______

Date of last time you met with your doctor: __________: Results: ____________________

Date of last complete physical examination: _________: Results: ____________________

ALLERGIES: Are you allergic to any foods, drinks, spices, etc: ____ No ___ Yes: Describe: __________
ALLERGIES: Are you allergic to any drugs/medicine: ____ No ___ Yes: Describe: ______________
ALLERGIES: Are you allergic to anything: ____ No ___ Yes: Describe: ____________________

Do you have chronic pain? ____ No ____ Yes: For how long? ________ From what? __________

DID YOU OR DO YOU NOW HAVE:

Blood borne illnesses: Such as Malaria, hepatitis, Sickle Cell etc: ____ No _____ Yes: Specify:
____

Cancer: bone, lung, breast, etc: ____ No _____ Yes: ______________________________

Digestive tract disorders: ____ No _____ Yes: __________________________________

Neurological issues: forgetful, cognitive, etc: ____ No _____ Yes: ____________________

Major physical/head trauma: car accidents, work injuries, military: ____ No _____ Yes: Describe:

____

Other illnesses which affect your mental health: ______________________________

WOMEN ONLY
Do you have any menstrual period problems? ___ No ___ Yes: Describe: __________________
Are you pregnant? ___ No ___ Yes: Due Date: __________ Are you receiving prenatal care? ___ No ___ Yes
Please check if you had: ____ pregnancies ___ Miscarriages ___ Stillbirths ____ Abortions LAST GYN: ______

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CLIENT HISTORIES

NAME: ______________________ ID# ____________________ Date: __________

FAMILY MEDICAL HISTORY

Father: Age: _____ Current Health: ______________________________________

Mother: Age: _____ Current Health: ____

Brother/sisters: Health Problems: ____

OTHER MENTAL HEALTH PROVIDERS:

Are you currently being treated or seen by any other mental health provider?

Counselor: ___ No ___ Yes: If YES: Name: ________________________ PH #: ____________

Psychiatrist: ___ No ___ Yes: If YES: Name: ________________________ PH #: ____________

***MEDICATIONS: From your PSYCHIATRIST/FAMILY DOCTOR/SPECIALISTS:* Please list all medications that you are currently taking:**

NAME	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

List any over the counter medications/dietary supplements/herbal/etc:

____

____

____

PLEASE NOTIFY YOU THERAPIST OF ANY CHANGES IN MEDICATION DURING COURSE OF THERAPY.

____

Client's Signature Date