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: _____

_____

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CLIENT HISTORIES

NAME: _____ **Birth Date:** _____ **Date:** _____

ADDRESS: _____
Street **Town** **State** **Zip**
TELEPHONE: _____
Home **Work** **Cell**
SEXUAL ORIENTATION: _____ **GENDER:** _____

CURRENT RELATIONSHIP STATUS: _____ **In Relationship** _____ **Single** _____ **Married** _____ **Divorced** _____ **Separated** _____ **Widowed**

PARTNER'S NAME _____

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: _____

CUMBERLAND VALLEY COUNSELING ASSOCIATES
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**