



Families First Counseling Services
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Client Information

Family's Last Name _____ Date _____

Person completing this form _____

Who referred you to FFCS? _____

Family Information

(Note: Include yourself in the following) If you are or have been married, complete for that family. If you are single, complete for your birth family including yourself. Begin with adults and then children oldest to youngest.

Name (first & last)	DOB	Sex	Relationship

Marital Status:

Never Married Partnered Married Separated Divorced Widowed Relationship Length _____

Home Address _____ H/P _____

City _____ State _____ Zip _____

Your Email & Cell Phone _____

Spouse Email & Cell Phone _____

May I contact you at home? Y__N__ Work? Y__N__ Cell? Y__N__ Email? Y__N__

May I contact spouse at home? Y__N__ Work? Y__N__ Cell? Y__N__ Email? Y__N__

In your own words, please state the problem that brings you to counseling:

MEDICAL AND PSYCHOTHERAPY HISTORY

Have you or anyone in your household been in therapy or counseling before? Y__ N__ If yes list below:

NAME	WHEN	WITH WHOM?	REASON

Are you or anyone in your household currently on medication? Y__ N__ If yes list below:

NAME	MEDICATION	DOSAGE	PHYSICIAN	REASON

FAMILY PHYSICIAN: Name _____ PHONE # _____

Specialists: If you or anyone in your family is presently seeing a specialist, (urologist, allergist, etc.) please provide the following information:

SPECIALIST: Name _____ Phone # _____

FAMILY MEMBER: _____ Reason _____

PAYMENT INFORMATION: Read "Fee Information and Agreement Form" before completing this part.

Who will be responsible for payment? _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)

Self: Poor Unsatisfactory Satisfactory Good Very good

Spouse: Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are there any problems with sleep habits? Self No Yes Spouse No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other _____

4. How many times per week do you exercise? _____ Spouse _____

Approximately how long each time? _____ Spouse _____

5. Are there any difficulty with appetite or eating habits? Self No Yes Spouse No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Has there been significant weight change in the last 2 months? Self No Yes Spouse No Yes

6. Regularly use alcohol? Self No Yes Spouse No Yes

In a typical month, how often are 4 or more drinks consumed in a 24-hour period? _____

7. Recreational drug use? Self No Yes Spouse No Yes

Frequency? Daily Weekly Monthly Rarely

8. Have there been suicidal thoughts recently? Self No Yes Spouse No Yes

9. Have there been any suicidal thoughts or attempts in the past? Self No Yes Spouse No Yes

10. Are there currently or have there been thoughts of hurting others? Self No Yes Spouse No Yes

	<u>Self</u>	<u>Spouse</u>
Have you ever experienced:		
Extreme depressed mood	yes/no	yes/no
Wild Mood Swings	yes/no	yes/no
Rapid Speech	yes/no	yes/no
Extreme Anxiety	yes/no	yes/no
Panic Attacks	yes/no	yes/no
Phobias	yes/no	yes/no
Sleep Disturbances	yes/no	yes/no
Hallucinations	yes/no	yes/no
Unexplained losses of time	yes/no	yes/no
Unexplained memory lapses	yes/no	yes/no
Alcohol/Substance Abuse	yes/no	yes/no
Frequent Body Complaints	yes/no	yes/no
Eating Disorder	yes/no	yes/no
Body Image Problems	yes/no	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no	yes/no
Homicidal Thoughts	yes/no	yes/no
Suicide Attempt	yes/no	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes Spouse? No Yes

If yes, who is your current employer/position? Self-_____

Spouse _____

If yes, are you happy at your current position? Self No Yes Spouse No Yes

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself religious? Self No Yes Spouse No Yes

If yes, what is your faith? Self-_____

Spouse _____

If no, do you consider yourself spiritual? Self No Yes Spouse No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<u>Difficulty</u>	<u>Family Member</u>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider your strengths?

What do you like most about yourself?

What are effective coping strategies that you have learned?

What are your goals for therapy?