

Bridges and Pathways Counseling Services
Twin Cities
Confidential Client Information

Today's Date: _____

Name **Date of Birth** **Age**

How did you hear about us? Doctor Insurance/EAP Family or Friend Internet Ad in paper
 Building Sign Other _____

Relationship Status: Single Married Domestic Partner in a serious relationship Divorced
 Widowed Other _____

Current Living Situation: House Apartment Other

Others Living With You: Spouse Minor Children Adult Children Parent Significant Other
 Roommate Other

Name of spouse or Significant other: _____

Names and Ages of Children: _____

Primary Physician: _____ **Phone:** _____
Name

Address

Psychiatrist: _____ **Phone:** _____

Address

Other or Previous Therapy _____ **Phone:** _____
Name of therapist

Dates of Therapy _____ **Outcome:** _____

Other Healthcare Provider: _____ **Phone** _____
Name

Address

Describe the reason for your visit today:

Symptoms and Issues: (check those you experience)

- | | | |
|---|---|--|
| <input type="checkbox"/> Anger, aggression, violence | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> School issues |
| <input type="checkbox"/> Anxious, worried | <input type="checkbox"/> Lying frequently | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Memory, concentration problems | <input type="checkbox"/> Sexual identity concerns |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Money management issues | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Difficulty being alone | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Shy, uneasy with others |
| <input type="checkbox"/> Alcohol, drug abuse | <input type="checkbox"/> Motivation is reduced, absent | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Eating habits, problems | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Suicidal thoughts, attempts |
| <input type="checkbox"/> Employment issues | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Tired, fatigued |
| <input type="checkbox"/> Gambling issues | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Unassertive |
| <input type="checkbox"/> Guilt feelings, shame | <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Unusual thoughts |
| <input type="checkbox"/> Hearing voices, hallucinations | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Physical self harm, cutting | Others: |
| <input type="checkbox"/> Living arrangements | <input type="checkbox"/> Relationship issues | |

When did symptoms and Issues begin? _____

How does this affect your ability to function:

at home? _____	socially? _____
at work? _____	emotionally? _____
at school? _____	spiritually? _____

Chemical Use:

What is the **highest number of drinks** you have had on a given day in the past year? _____

- Have there been consequences of your alcohol or chemical use? yes no
- Have you ever been concerned about your own alcohol or chemical use? yes no
- Have other expressed concern to you about your alcohol or chemical use? yes no
- Have others who are close to you abused alcohol or drugs yes no
- If yes, who? _____
- Have you attended alcohol or chemical treatment yes no
- Have you/do you attend a support group for alcohol or chemical abuse? (AA, NA) yes no

Abuse History: (check those you have experienced, now or in the past)

- Emotional Abuse: in the past currently not sure towards you by you
- Physical Abuse: in the past currently not sure towards you by you
- Verbal Abuse: in the past currently not sure towards you by you
- Sexual Abuse: in the past currently not sure towards you by you

Medical Issues:

Current Medication:

Name of medication:	Dosage:	Start Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

List hobbies, interests: _____

Educational History: Highest level of education: _____

Education problems? _____

Learning disabilities? _____

Employment History:

Are you currently employed? yes no If yes, occupation: _____

Any current or past employment problems? _____

Military History:

Have you served in the military? yes no

If yes, what branch? _____

Reason for leaving the military? _____

Religion, Spirituality:

Do you have spiritual beliefs you would like to discuss? yes no

Do you have a religious/spiritual affiliation? yes no

If yes, what denomination? _____

Ethnicity:

What is your ethnic background? _____

Services You Receive:

County Social Worker Legal services Life skills worker Probation Officer

County services Other: _____

Your Expectations: What do you hope to gain from counseling?

