

BETH M. WARREN, M.A.,LPC
1930 E. ROSEMEADE PKWY., SUITE 209
CARROLLTON, TEXAS 75007
972-523-7322
mbmwarren@tx.rr.com

Date: _____

Client Information

Name: _____
 First Middle Initial Last

Address: _____

Date of Birth _____ Email _____

Phone: (____) _____ (____) _____ (____) _____
 Home Work Cell
 May I contact you at these numbers? (Y/N) Home _____ Work _____ Cell _____

Spouse / Guardian Information

Name: _____
 First Middle Initial Last

Date of Birth _____ Email _____

Phone: (____) _____ (____) _____ (____) _____
 Home Work Cell

May I contact you at these numbers? (Y/N) Home _____ Work _____ Cell _____

Other Information

Briefly, describe the issue(s) that caused you to seek counseling:

Have you sought counseling in the past? _____ What was the duration and outcome of past counseling experience? (Please include the name of the person you saw, dates of counseling, and outcome of counseling)

Do you have any history of abuse? _____ What type? Physical Emotional Sexual

Have you experienced any loss such as a death or any trauma in the past 5 years? _____ If so, please describe:

Employment Information

Employer's name: _____ Position held: _____

Spouse's employer: _____ Position held: _____

Medical Information

Current medications:

Do you have any current health problems or recent illnesses or operations?

How often do you currently use alcohol and how much do you consume at a time?

Has your alcohol usage been significantly higher at another point in your life? Please describe?

Do you use tobacco, and if so, how often? _____

Do you have any history in the past 10 years of drug use, and if so, what kind and how often?

Are you currently using any drugs, and if so, what kind and how often?

Is there any history of alcohol or drug abuse in your family, either currently or in your family of origin?

How many hours do you sleep at night? _____ Do you have any difficulty sleeping? _____ Please describe:

Have you gained or lost more than 10 lbs. in the past year? _____ was this intentional? _____

Have you ever attempted to end your own life? _____ When and what happened?

In the past two months, have you experienced any of the following:

Yes No

- ___ ___ Jittery, nervous feelings
___ ___ Shortness of breath
___ ___ Heart racing
___ ___ Thoughts of wishing to be dead
___ ___ Thoughts of ending your own life
___ ___ Desire to cut or self-mutilate
___ ___ Actions of cutting
___ ___ Feelings of rage
___ ___ Feelings of hopelessness
___ ___ Feelings of loneliness
___ ___ Feelings of sadness

Family History

How old are your parents?

If you have lost your parents, when did you lose them and how old were you?

Are your parents divorced? _____ How old were you when they divorced? _____ Remarriage (s) ?

Number of siblings, names and ages?

Would you describe your family as: Warm Average Hostile

Would you say your family: Allowed great independence Average Attempted to control

Date of current marriage: _____ Age when married: _____

Briefly give information about previous marriages, date, length, etc:

Dependents:

Name	Relations	DOB	Current/Previous Marriage

Is there any other information you would like me to know?

Church Affiliation? _____

Who were you referred by? _____