

PLEASE PRINT ALL INFORMATION LEGIBLY

## Hope for Tomorrow Counseling Services

### Consumer Information:

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_ Social Security Number (9 digits) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Parent/Legal Guardian Information (if consumer is under age 18)

Name: \_\_\_\_\_ Relationship to Consumer: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contacts: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### Insurance Information (Please complete the following information so we can file claims with your Insurance Company.)

Insurance Provider: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Address/Phone: \_\_\_\_\_

Who is responsible for copayments & deductibles? \_\_\_\_\_

*\*\*Please complete the remainder of this form for the person who is presenting for counseling.\*\**

### Current School Information

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical Information

Allergies: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist's Name (if applicable): \_\_\_\_\_ Phone \_\_\_\_\_

Significant Medical Problems (past or present): \_\_\_\_\_

Medication	Dosage	Frequency	Current Yes/No	Purpose/Effectiveness
			Yes/No	
			Yes/No	

			Yes/No	
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Any Previous Mental Health and/or Substance Abuse Treatment?  Yes (specify below)  No

Therapist or Program	Dates (From/To)	Purpose/Completed

Have you ever attempted to harm yourself? No Yes

Have you made efforts to physically harm another person or animal? No Yes

If you answered yes to either question above, please explain:

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Please circle the following issues that have been a problem for you:

- |                       |                           |                  |
|-----------------------|---------------------------|------------------|
| Depression            | Concentration             | Impulsive        |
| Loss of family member | Temper outburst           | Legal Problem    |
| Sadness               | Anger control             | Health Problem   |
| Suicidal Thoughts     | Difficulties with friends | Marital Problem  |
| Shyness               | Isolation                 | Bed wetting      |
| Sleep difficulties    | Relationships             | Eating Problems  |
| Lack of Motivation    | Obsessive Thinking        | Loneliness       |
| Self-esteem issues    | School behavior problems  | Nightmares       |
| Anxiety Attacks       | Sexual Abuse              | Extreme Fears    |
| Nervousness           | Weight gain/loss          | Underachievement |
| Worry                 | Sexuality                 | Lack of energy   |
| Identity              | Conflict                  |                  |

Reason you are currently seeking therapy: \_\_\_\_\_

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In order to obtain a comprehensive assessment, please circle any of the areas that apply to the consumer's family (including extended family on both mother and father's side of the family).

- |                                    |                            |
|------------------------------------|----------------------------|
| Drug/Alcohol use                   | Eating Problems            |
| Anxiety                            | Sexual Abuse               |
| Depression                         | Physical Abuse             |
| Suicide                            | Domestic Violence          |
| Schizophrenia                      | Attention Deficit Disorder |
| Hospitalization for Mental Illness | Bipolar Disorder           |

Please add any additional information you think would be helpful:

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\_\_\_\_\_ Date

\_\_\_\_\_ Signature