Date:

Frame of Mind Counseling

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Client Information

Client full name: _____

Preferred name: _____

Maiden/former name: _____

Marital/relationship status: _____

Sex: _____ Gender: _____ Pronouns: _____

Age: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Preferred method of contact: ▭ Call ▭ Text ▭ Email

May we leave a message? ▭ Yes ▭ No

Highest level of education: ▭ Elementary/Middle School ▭ High School ▭ GED/HiSet

▭ Trade School ▭ Some College ▭ College ▭ Graduate School

Occupation: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Closest loved one not living with you: _____

Relationship: _____ Phone: _____

Emergency contact: _____

Relationship: _____ Phone: _____

How did you hear about our office? _____

Presenting Problem

Briefly describe your current issues.

_____

How long has this problem been of concern?

_____

What made you decide to seek counseling at this time?

_____

What seems to help this problem?

What seems to make it worse?

Have any other family members had this problem?

Have you experienced any major events or trauma (move, death, abuse)?

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe your faith or belief?

How do you think counseling will help?

Medical History

Name of family physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

When was your last physical exam? _____

Physical condition/diagnosis: _____

Any major childhood illness? _____

Current medications:

Medication	Length of Time	Condition Being Treated

Past medications:

Have you ever been hospitalized for mental illness? ☐ Yes ☐ No

If yes, name of hospital: _____

Have you ever received a psychological evaluation or treatment for the current problem, or similar problems in the past?

☐ Yes ☐ No

If yes, where and with whom? _____

May we contact your doctor/mental health professional? ☐ Yes ☐ No

Do you currently have suicidal thoughts? ▭ Yes ▭ No

If so, how often? _____ Means: _____

Do you have a plan? ▭ Yes ▭ No

If yes, what is your plan?

_____

Do you currently have thoughts of harming others? ▭ Yes ▭ No

If so, how often? _____ Means: _____

Do you have a plan? ▭ Yes ▭ No

If yes, what is your plan?

_____

Payment Information if person responsible for payment is not the client

Name: _____

Relationship to client: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Credit card to keep on file

Name on card: _____

Card number: _____

Expiration date: _____

Security number: _____

Billing address: _____

City: _____ State: _____ Zip: _____