

Positive Change Counseling Center

Phone: 619.733.1085

5480 Baltimore Drive #250 La Mesa, CA 91942

**CLIENT INFORMATION**

Date of 1<sup>st</sup> Appointment: \_\_\_\_\_ Referral Source: \_\_\_\_\_

(Please indicate all those participating):

**ADULTS**

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	OCCUPATION	RELATIONSHIP TO CLIENT (or Self")

**CHILDREN**

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	LEGAL GUARDIAN	RELATIONSHIP TO CLIENT (or "Self")

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

*(OK to contact you here?)*

Phone #s: Home: \_\_\_\_\_ (Y\_ N\_)(msg\_)

Work: \_\_\_\_\_ (Y\_ N\_)(msg\_)

Cell: \_\_\_\_\_ (Y\_ N\_)(msg\_)

Email: \_\_\_\_\_ (Y\_ N\_)(msg\_)

Emergency Contact Person: \_\_\_\_\_

Relationship to Client/Family: \_\_\_\_\_

Contact #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Physician's #: \_\_\_\_\_

Medications/For What: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

*(Continued on next page)*

1) Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

---

---

---

---

---

2) Please rate the severity of the following symptoms over the last month according to the following rating scale:

**0-No difficulty**  
**1-Mild**  
**2-Moderate**  
**3-Severe**

- |   |   |
|---|---|
| <input type="checkbox"/> Decreased appetite   | <input type="checkbox"/> Nightmares                         |
| <input type="checkbox"/> Increased appetite/eating more   | <input type="checkbox"/> Hypervigilance                     |
| <input type="checkbox"/> Binging and/or purging   | <input type="checkbox"/> Obsessive thoughts                 |
| <input type="checkbox"/> Weight change? +/- ____ lbs.   | <input type="checkbox"/> Compulsions                        |
| <input type="checkbox"/> Depressed mood   | <input type="checkbox"/> Spending sprees                    |
| <input type="checkbox"/> Decreased energy/fatigue   | <input type="checkbox"/> Racing thoughts                    |
| <input type="checkbox"/> Sleep changes: trouble falling asleep;<br>trouble staying asleep; trouble<br>waking up ( <i>circle one</i> ) | <input type="checkbox"/> Rapid heart beat                   |
| Avg. # hours sleep ____   | <input type="checkbox"/> Trouble breathing                  |
| <input type="checkbox"/> Decreased sexual desire  | <input type="checkbox"/> Sweating                           |
| <input type="checkbox"/> Difficulty with sexual functioning   | <input type="checkbox"/> Phobia                             |
| <input type="checkbox"/> Loss of interest in activities   | <input type="checkbox"/> Police/Probation involvement       |
| <input type="checkbox"/> Crying   | <input type="checkbox"/> Stealing                           |
| <input type="checkbox"/> Feelings of hopelessness   | <input type="checkbox"/> Lying                              |
| <input type="checkbox"/> Feelings of helplessness   | <input type="checkbox"/> Truancy                            |
| <input type="checkbox"/> Decreased attention span   | <input type="checkbox"/> Violent behavior towards<br>others |
| <input type="checkbox"/> Inattentive/Distractible   | <input type="checkbox"/> Destruction of property            |
| <input type="checkbox"/> Memory problems: Long-term;<br>short-term  | <input type="checkbox"/> Harming animals                    |
| <input type="checkbox"/> Self-injurious behavior  | <input type="checkbox"/> Fire setting                       |
| <input type="checkbox"/> Thoughts of suicide  | <input type="checkbox"/> Opposition                         |
| <input type="checkbox"/> Thoughts of harming others   | <input type="checkbox"/> Anger outbursts                    |
| <input type="checkbox"/> Impulsivity  | <input type="checkbox"/> Irritability                       |
| <input type="checkbox"/> Hyperactivity  | <input type="checkbox"/> Substance Abuse                    |
| <input type="checkbox"/> Anxiety/Nervousness  | <input type="checkbox"/> ____ Alcohol                       |
| <input type="checkbox"/> Worry/Fear   | <input type="checkbox"/> ____ Illicit Drugs                 |
| <input type="checkbox"/> Flashbacks of traumatic event  | <input type="checkbox"/> ____ Prescription Drugs            |
| <input type="checkbox"/> Difficulties making decisions  | <input type="checkbox"/> Spending time with others          |
|   | <input type="checkbox"/> Self-esteem                        |

3) Please identify any history of abuse/trauma:

- Physical Abuse     Sexual Trauma     Emotional Abuse  
 Witnessed Violence     Combat Trauma

(Continued on next page)

4) What would you like to see accomplished in therapy?

---

---

---

---

5) Have you or other members of your family ever received counseling or mental health services before? If so, please list dates, provider name, the issue for which services were sought, and what you feel was accomplished:

---

---

---

---

6) Please list any medications and/or other treatments you are receiving at this time (i.e., prescription/over-the-counter medications, medical care, acupuncture, chiropractic care, substance abuse treatment, etc.):

---

---

---

---

7) **Insurance Information** (if applicable):

Person Responsible for Payment: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name & Address: \_\_\_\_\_

---

Subscriber's SS#: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Subscriber's Employer's Name: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

Secondary Insurance? \_\_\_\_\_