

**Gretchen Flores, LPC, LCPC**  
**Licensed Clinical Professional Counselor**

**FIRST APPOINTMENT FORM**

Please fill out the following form. All of this information will be kept confidential (note exceptions in the counselor disclosure form). Please keep your responses brief as we will have time to discuss them in further detail later. Please respond honestly as this will help me to assess your needs and decide the best course of action for you. Also please print legibly. Thank you! Only fill out what you are comfortable with.

**CLIENT CONTACT INFORMATION:**

**Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_  
\_\_\_\_\_

**Parent/ Guardian Name (if under 18):** \_\_\_\_\_

**PHONE CONTACTS:**

**May I leave a message? (circle one)**

**Mobile Phone number:** \_\_\_\_\_ **Yes** **No**

**Home Phone number:** \_\_\_\_\_ **Yes** **No**

**Work Phone number:** \_\_\_\_\_ **Yes** **No**

**Other Phone number:** \_\_\_\_\_ **Yes** **No**

**Email address:** \_\_\_\_\_ **May I email you? Yes No**

**Referred by:** \_\_\_\_\_

**EMERGENCY CONTACT:**

**Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**I give my permission to contact this person in the case of an emergency: Yes No Initial** \_\_\_\_\_

**CURRENT CONCERNS:**

What are your current primary concerns:

How severe is this difficulty? (check one)

Mild                     Moderate                     Severe                     Incapacitating

When did this difficulty begin?

How often do you experience difficulty?

Daily  
 Weekly  
 Monthly

Please explain:

Have you been in therapy or treatment in the past? How long ago?

Have you been hospitalized in the past? How long ago? What for?

|                                 |     |    |
|---------------------------------|-----|----|
| Have you had suicidal thoughts? | Yes | No |
| Are you suicidal now?           | Yes | No |

If yes, please explain how often you feel this way and how intense your thoughts are:

If yes, what prevents you from following through on your thoughts?

If you are not suicidal, do you sometimes wish you just wouldn't wake up in the morning?

**MEDICATIONS:**

Please list current medications, dosages, and what they are for (Please be sure to fill this out).

None\_\_\_\_\_ (check if you are not taking medication)

| Medication: | For: | Dosage: | AM or PM? |
|-------------|------|---------|-----------|
| 1. _____    |      |         |           |
| 2. _____    |      |         |           |
| 3. _____    |      |         |           |
| 4. _____    |      |         |           |
| 5. _____    |      |         |           |

List supplements that you take:

**STRENGTHS AND RESOURCES:**

What do you hope to get out of counseling?

What has helped you with this issue in your life (friends/family/community/group support)?

What do you consider to be **personal strengths** to help address this issue?

Do you have any hobbies?

Do you exercise? How often?

**CURRENT SYMPTOM CHECKLIST:**

**Check and Circle all that apply:**

\_\_\_\_\_ Crying easily

\_\_\_\_\_ Sleep problems;    Sleep too much    Wakefulness    Nightmares

Explain:

\_\_\_\_\_ Difficulty concentrating

\_\_\_\_\_ Anger

\_\_\_\_\_ Outbursts (Expressions of anger or frustration)

\_\_\_\_\_ Panic Attacks

Explain:

\_\_\_\_\_ Phobias/Fears

Explain:

\_\_\_\_\_ Memory loss

\_\_\_\_\_ Hearing voices

\_\_\_\_\_ Feelings of hopelessness

\_\_\_\_\_ Excessive fatigue

\_\_\_\_\_ Excessive energy    Frequency: \_\_\_\_\_

\_\_\_\_\_ Excessive energy followed by excessive fatigue

\_\_\_\_\_ Obsessive (repetitive) thoughts    About \_\_\_\_\_

\_\_\_\_\_ Obsessive actions (i.e. checking doors, washing hands)

Explain:

\_\_\_\_\_ Risk taking (i.e. overspending, driving too fast)

\_\_\_\_\_ Apathy or lack of enthusiasm about life

\_\_\_\_\_ Relationship problems/changes

\_\_\_\_\_ Eating problems;    Overeating            Under-eating            Purging

Explain:

\_\_\_\_\_ Substance misuse;    Alcohol    Prescriptions    Other drug \_\_\_\_\_

Explain:

\_\_\_\_\_ Suicidal thoughts;    Attempts?    Y    N    How long ago?    Hospitalized?    Y    N

\_\_\_\_\_ Decrease in activities you used to enjoy

\_\_\_\_\_ Slowed bodily movements

\_\_\_\_\_ Worry    About: \_\_\_\_\_

\_\_\_\_\_ Startle easily

\_\_\_\_\_ Indecisiveness

\_\_\_\_\_ Experienced a traumatic event

Explain:

\_\_\_\_\_ Negative self-perception

\_\_\_\_\_ Muscle tension

\_\_\_\_\_ Frequent headaches

\_\_\_\_\_ Other Symptom that bothers you:

Explain:

**EMPLOYMENT:**

Name of Company:

Current Position:

Is your work satisfying to you?

**HEALTH QUESTIONS:**

Current physical health status:      Poor                  Fair                  Good                  Excellent

Explain:

Do you drink diet soda? If so, how often?

Do you eat a healthy diet?

Do you use recreational drugs? What kind and how often?

Do you consider your recreational drug use to be a problem?    Yes    No

Do you drink alcohol?                          What kind?                          How often?

Do you consider the amount you drink to be a potential problem?    Yes    No

Has anyone told you that they thought your substance use was a problem?    Yes    No

**FAMILY HISTORY:**

Please check/circle all that apply:

\_\_\_ Parents divorced      Age:  
\_\_\_ Mother Remarried      Age:  
\_\_\_ Father Remarried      Age:

\_\_\_ Depression              Paternal Side              Maternal Side  
\_\_\_ Anxiety                  Paternal Side              Maternal Side  
\_\_\_ Alcohol/drug abuse      Paternal Side              Maternal Side  
\_\_\_ Bi-Polar Depression      Paternal Side              Maternal Side  
\_\_\_ Schizophrenia              Paternal Side              Maternal Side  
\_\_\_ Other \_\_\_\_\_      Paternal Side              Maternal Side

**PERSONAL HISTORY:**

Have you experienced:

\_\_\_ Physical abuse  
\_\_\_ Sexual abuse  
\_\_\_ Emotional abuse  
\_\_\_ Domestic Violence  
\_\_\_ Other

Explain:

During your childhood who raised you?

What was your family like?

Relationship: Name of spouse or partner: \_\_\_\_\_

Single                      Married                      Separated  
Divorced                      Widowed                      Common-law Married

What (if any) concerns do you have in your marriage/partnership?

Children:

|    | Name  | Age   |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

**SPIRITUAL PREFERENCES:**

Please indicate your spiritual faith (If applicable):

How important are your personal spiritual beliefs?

\_\_\_\_Not Important    \_\_\_\_Somewhat Important    \_\_\_\_Important    \_\_\_\_Very Important

Are you involved in community in your faith? Yes No

Is there anything else significant that you think is important:

\*Thank you. I look forward to working with you. ***This is an assessment only.*** Referrals to other supports or resources may be made, if deemed appropriate, to make sure you have the level of care that is the best fit for you.