River Bend Counseling

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CONFIDENTIAL CONTACT INFORMATION

The following information will help us get to know you. Please fill out this form and bring it to your first session.

_____ _____ _____
Client's Last Name First Name Middle Initial

_____ _____ _____
Date of Birth Age Gender

_____
Address: Number and Street

_____ _____ _____
City State Zip

Preferred Telephone Contact Number: _____

Emergency Contact: _____ _____
Name Phone

Referred by: _____

Is it acceptable to contact you at home? Y/N
If "no" then how can I contact you? _____

Are you currently under medical care? Y/N
If "yes", then please explain/describe

_____
_____
_____

Name of personal physician & phone number

_____

Are you currently taking prescribed medications? Y/N
If "yes", then please explain/describe

_____
_____

List any psychiatric/mental health medications you have taken

_____
_____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y/N
If "yes", please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention.

_____
_____
_____

What has led you to seek counseling or evaluation at this time:

_____
When did these concerns or struggles develop?

_____
Have you ever attempted suicide or made any self-harm attempts: YES NO If yes, how long ago was the last attempt:

_____
Do you have current thoughts of ending your life or harming yourself: YES NO If yes, what is your plan:

_____
Do you have current thoughts of harming anyone else: YES NO If yes, what is your plan:

_____

Please circle any of the following struggles that pertain to you:

Anxiety Depression Fears/Phobias Eating Disorders Sexual Problems Suicidal Thoughts

Separation/Divorce Finances Drug/Alcohol use Career Choices Anger

Self-Control Unhappiness Insomnia Religious Matters Work/stress

Health problems Cutting/self-harm Thought Patterns Sexual abuse history Sleep problems

Emotional or physical abuse Other:_____