Symmetry Counseling

A Limited Liability Company

Please take the time to complete this form thoroughly.
Please bring this completed form as well as the attached documents in your first appointment. Thank you!

Couple's Identifying Information:

1 Name ____ Age _______ Birth date _____________

Occupation ___________________________________ Employer _______________________________

Physician ______________________________________ Phone _______________ Last visit __________

#2 Name ____ Age _______ Birth date _____________

Occupation ___________________________________ Employer _______________________________

Physician ______________________________________ Phone _______________ Last visit __________

Address: street _______________________________ city/state ____________________ zip _________

Phone: home __________________________ work ____________________ cell __________________

Emergency Contact ____ phone ________________

How did you hear about me? ____

Present living situation: (circle one)

group partner/spouse family w/parents other _____________________

Do you have children?

Child's Name	*Age*	*Living With*	*Relationship to: (which client)*

Client # 1 Health (NAME ____)

Please describe your general health and list any medical problems ______________________________

____

Allergies (including medication allergies) ____

How many hours per week do you work _____ exercise ______ Type of exercise ___________________

Are you comfortable with your weight? ______ *why/why not?* ____________________________________

How many hours a night do you sleep? _____ Do you sleep well through the night? __________________

Do you have problems sleeping? ________ *if so, when?* ____

Have you or a partner ever had a miscarriage? ____ *when?* _______________________________________

Abortion? _____ *when?* ____

Are you troubled by any fears/worries/anxieties? ___________ *Please describe* _______________________
____

Have you ever attempted suicide? ____ *when?* ____________ *how?* _________________________________

Has anyone ever expressed concern about your health? _____ *please explain* ___________________________
____

Has anyone ever expressed concern about your eating habits or weight? ____ *please explain* _____________
____

Has anyone ever expressed concern about your drinking or drug use? _____ *please explain* ______________
____

History

Do you have brothers and/or sisters?

Name	*Age*	*Medical/Emotional Problems*	*Living?*

How did your family deal with problems or conflict while you were growing up?
Circle all that apply

Spank Kick Tease Ridicule Slap Shame Discuss Yell Push Lecture Threaten Deny Problems Problem Solve Withdraw Emotionally Leave Ignore Blame Listen with Respect Escape into Compulsive Behavior Seek Help From Others

Is there any history of mental illness or emotional problems in your family? *Please describe:*
____

Have any of your relatives ever experienced a problem with alcohol or drugs? _______ *If so who?*
____
Have you ever been sexually abused? ____
Have you ever been in a situation in which you were touched in a way that made you feel unsafe or uncomfortable? ____

Have any family or friends ever attempted or committed suicide? ______ *If so who?* ______________________

Have you ever experienced the death of a close family member or a friend? ______ *Who and When?*
____

Present Concerns

In your present life, how do you deal with problems or conflicts? *Circle all that apply*

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What events, experiences, or changes have led you to choosing to come into counseling?
____

What specific issues do you want to work on in counseling? ____
____

Have you work on them before? _____ When and with whom? _______________________________________
____
____

Please mention any other special concerns, history or information that might be helpful for me to know in working with you ____
____

Client # 2 Health (NAME____)

Please describe your general health and list any medical problems ___________________________________

____

Allergies (including medication allergies) ____

How many hours per week do you work ______ exercise ______ Type of exercise ____________________

Are you comfortable with your weight? ______ *why/why not?* ____

How many hours a night do you sleep? _____ Do you sleep well through the night? __________________

Do you have problems sleeping? ________ *if so, when?* ____

Have you or a partner ever had a miscarriage? ____ *when?* ____

Abortion? ______ *when?* ____

Are you troubled by any fears/worries/anxieties? ______________ *Please describe* ______________________
____

Have you ever attempted suicide? ____ *when?* _____________ *how?* ___________________________________

Has anyone ever expressed concern about your health? _____ *please explain* _____________________________
____

Has anyone ever expressed concern about your eating habits or weight? ____ *please explain* ______________
____

Has anyone ever expressed concern about your drinking or drug use? ______ *please explain* ______________
____

History

Do you have brothers and/or sisters?

Name	*Age*	*Medical/Emotional Problems*	*Living?*

How did your family deal with problems or conflict while you were growing up?
Circle all that apply

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Is there any history of mental illness or emotional problems in your family? *Please describe:*
____

Have any of your relatives ever experienced a problem with alcohol or drugs? _______ *If so who?*
____

Have you ever been sexually abused? ____

Have you ever been in a situation in which you were touched in a way that made you feel unsafe or uncomfortable? ____

Have any family or friends ever attempted or committed suicide? ______ *If so who?* ____________________

Have you ever experienced the death of a close family member or a friend? ______ *Who and When?*
____

Present Concerns

In your present life, how do you deal with problems or conflicts? *Circle all that apply*

Spank Kick Tease Ridicule Slap Shame Discuss Yell Push Lecture Threaten Deny Problems Problem Solve Withdraw Emotionally Leave Ignore Listen with Respect Blame Escape into Compulsive Behavior Seek Help From Others

What events, experiences, or changes have led you to choosing to come into counseling?
____

What specific issues do you want to work on in counseling? _______________________________________
____

Have you work on them before? _____ When and with whom? ____________________________________
____
____

Please mention any other special concerns, history or information that might be helpful for me to know in working with you ____
____

Your counseling session is on _________________ at ________
If you are unable to keep your appointment, please call to cancel at least 24 hours in advance.
Please read the enclosed policy statement, sign it, and bring both it and this form to your session.

DATE YOU COMPLETED THIS FORM ______________________________