



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 Policy Statement in your first appointment. Thank you!

Identifying Information:

Name _____ Age _____ Birth date _____

Address: street _____ city/state _____ zip _____

Phone: home _____ work _____ cell _____

Emergency Contact _____ phone _____

Occupation _____ Employer _____

Physician _____ Phone _____ Last visit _____

How did you hear about me? _____

Present living situation: (circle one)

Alone group partner spouse family single parent

roommate w/parents other _____

Do you have children?

Child's Name Age Living With Relationship (bio, step, adopted)

Child's Name	Age	Living With	Relationship (bio, step, adopted)

Do you have brothers and/or sisters?

Name Age Medical/Emotional Problems Living?

Name	Age	Medical/Emotional Problems	Living?

Ethnic/cultural/religious background _____

Health

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

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
Escape into Compulsive Behavior Listen with Respect Blame 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*

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