Morning Glory Counseling, PLLC

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CLIENT INFORMATION

Client Name(s): _____

Name of Parent/Guardian (if under 18 years of age)**:** _____

Client DOB: _____/_____/_____ **Age(s):** _____ **Occupation:** _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other: _____

Marital Status: ☐ Never Married ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _____

Please List Any Children/Age(s): _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Mobile Phone #: _____ **OK to Leave a Message:** ☐ YES ☐ NO

OK to Send Texts: ☐ YES ☐ NO

Other Phone #: _____ **OK to Leave a Message:** ☐ YES ☐ NO

Email Address: _____ **OK to Email Messages:** ☐ YES ☐ NO

Referred By (if applicable): _____

INSURANCE INFORMATION

Name of Insured: _____ **Insurance Company:** _____

Member Number: _____ **Group Number:** _____

Insured DOB: _____ /_____ /_____ **Insured Employer:** _____

Insured Email Address (if different from client): _____

IN CASE OF EMERGENCY

Emergency Contact: _____ **Relationship to Client:** _____

Emergency Contact's Phone #: _____

Do I have your permission to contact this person in the case of an emergency? ☐ YES ☐ NO

Please complete the following questions with as much information as you feel comfortable sharing. If you have any questions, please ask during your session:

1. Briefly, describe what is going on in your life which resulted in this appointment? _____

_____

_____

2. What would you like to see accomplished in therapy? _____

_____

_____

CURRENT COMPLAINTS OVER THE PAST 6 MONTHS (check all that apply to you):

_____ Depression
_____ Fatigue/Low energy
_____ Poor Concentration
_____ Worthlessness
_____ Hopelessness
_____ Helplessness
_____ Shame
_____ Guilt
_____ Feel Numb or Detached from Others
_____ Social Withdrawal/Isolation
_____ Thoughts about hurting yourself
_____ Thoughts about hurting others
_____ Unpleasant thoughts that won't go away
_____ Change in Weight (more or less)
_____ Appetite Disturbance (more or less)
_____ Sleep Disturbance (more or less)
_____ Nightmares

_____ Grief/Loss
_____ Anxiety
_____ Hypervigilance ("easily startled")
_____ Racing Thoughts
_____ Panic Attacks
_____ Phobias (please list: _____)
_____ Irritability
_____ Anger Outbursts (verbal or physical)
_____ Delusions/Hallucinations
_____ Impulsivity
_____ Verbal Abuse (present, past, or both)
_____ Emotional Abuse (present, past, or both)
_____ Physical Abuse (present, past, or both)
_____ Sexual Abuse (present, past, or both)
_____ Parenting Issues
_____ Family Problems
_____ Marital Problems

3. Do you drink alcohol? ☐ YES ☐ NO How many drinks a week? _____

_____

4. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

_____

5. Have you ever struggled with any addictive behaviors (substance abuse, alcohol, prescription medication, excessive spending, excessive gambling, pornography, etc.)? _____

_____

6. Have you ever struggled with self-harm? ☐ YES ☐ NO

If yes, please specify dates and method: _____

7. Have you ever seen a therapist before? ☐ YES ☐ NO

If yes, when and for what reason? _____

_____

What was accomplished? _____

8. **Have you ever seen a psychiatrist?** ☐ YES ☐ NO

   If so, when and for what reason? _____

9. **Are you currently being prescribed any medication(s)?** ☐ YES ☐ NO

   Please list all current medications prescribed by a psychiatrist or other medical practitioner *(feel free to attach a page):*

MEDICATION	DOSAGE	PRESCRIBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. **List any current or previous mental health diagnoses:** _____

    _____

11. **Any previous psychiatric hospitalization(s)?** ☐ YES ☐ NO **Number of Hospitalizations:** _____

NAME OF HOSPITAL	REASON FOR ADMISSION	DATES
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. **Primary Care Physician:** _____ **Last Medical Exam:** _____

    List any medical problems or diagnoses you are currently experiencing: _____

    _____

    Physician(s) monitoring condition(s): _____

13. **Are you currently or have you ever served in the Military?** ☐ YES ☐ NO

    If yes, please list branch, MOS/specific job, number and location of any combat deployments, years of service, and if active duty, reserve, or retired:

    _____

    _____

    _____

14. **Are you currently or have you ever worked/volunteered as a first responder (Police Officer, Firefighter, medical technician, etc.)?** ☐ YES ☐ NO

    If yes, please list specific job, location, and years of service as well as whether still currently serving your community in this respect or retired from service:

    _____

    _____

    _____

15. **Have you ever experienced a traumatic event?** ☐ YES ☐ NO

If yes, please check all that apply:

_____ War
_____ Military Sexual Trauma
_____ Adult Non-Military Sexual Trauma
_____ Adult Survivor of Violence or Physical Abuse
_____ Childhood Physical Abuse
_____ Childhood Sexual Abuse
_____ Having a Loved One Die Through Homicide or Suicide
_____ Natural Disaster
_____ Seeing Someone Seriously injured or Killed
_____ Vehicular Accident
_____ Other (please specify):

16. **Were there any significant childhood events or illnesses?** _____

_____

_____

17. **What other traumatic events or childhood adversity have you experienced (abuse, neglect, abandonment, financial hardships, etc.)?** _____

_____

_____

_____

_____

18. **Is there anything else important I need to know, but have not asked about?**

_____

_____

_____

_____

_____