



**Center for Counseling
Initial Information**

Please complete this form. If you need assistance for any reason, your counselor can go over the form with you. The information you share will assist us in providing the best service possible. Thank you.

Date _____ **Name(s)** _____

Please list: Name of person(s) seeking services	Date of Birth	Gender: (circle one)	Relationship to person filling out form
		M F	
		M F	
		M F	

Name, age, gender and relationship of others in the household with the person seeking services:

What concerns have brought you here today?

Please check all areas below that are of concern to you right now:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> family | <input type="checkbox"/> work | <input type="checkbox"/> trauma |
| <input type="checkbox"/> school | <input type="checkbox"/> loss/grief | <input type="checkbox"/> addiction |
| <input type="checkbox"/> relationships | <input type="checkbox"/> self-esteem | <input type="checkbox"/> substance abuse |
| <input type="checkbox"/> parenting | <input type="checkbox"/> sexuality | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> sadness/depression | <input type="checkbox"/> health | <input type="checkbox"/> child behavioral concerns |
| <input type="checkbox"/> stress/anxiety | <input type="checkbox"/> abuse | |

Please rate the severity of the problem(s) that bring(s) you here:

Most severe 1 2 3 4 5 6 7 8 9 10 Least Severe

What do you consider your primary language? _____

Please describe some of your strengths: _____

For statistical purposes, it is helpful if you identified your ethnicity, however, your response is optional:

What is your current relationship status? _____

Are you employed? (circle one) Yes No

If yes, where? _____

What do you do at your place of employment? _____

To help your counselor better understand your overall well being, please rate and describe how you are doing in the following areas of your life. Indicate your rating by circling a number in each area according to the following scale: Low Well Being 1 2 3 4 5 6 7 8 9 10 High Well Being

School/Work: 1 2 3 4 5 6 7 8 9 10 _____

Home environment: 1 2 3 4 5 6 7 8 9 10 _____

Extended family: 1 2 3 4 5 6 7 8 9 10 _____

Social relationships: 1 2 3 4 5 6 7 8 9 10 _____

Emotional Well-being: 1 2 3 4 5 6 7 8 9 10 _____

Cultural Issues: 1 2 3 4 5 6 7 8 9 10 (Issues related to culture, race, ethnicity, gender, disability, sexual orientation or religion) _____

How well are you doing overall? 1 2 3 4 5 6 7 8 9 10 _____

Please list any significant events occurring throughout your life regarding health, trauma or loss:

Please note any different or special needs we should be aware of: _____
