Healing Journeys Counseling LLC
Kelly Carlson MC, LPC, NCC (480) 734-7870
2929 N. Power Rd. Suite C3 **15821 E. Kim Dr**
Mesa, AZ 85215 **Fountain Hills, AZ 85268**

How were you referred? _____

CLIENT INFORMATION

Name _____DOB_____Age_____ __Male __Female

Home Address_____

City_____ State_____ Zip _____ Ok to mail? __Yes __No

Phone _____ Ok to call? __Yes __No Ok to leave message? __Yes __No
Ok to text reminder? ___Yes ____No

Email address we can contact you at _____ Send Y N

Relationship Status _____ Occupation _____

Children Name(s) & age _____

_____

Emergency Contact Other/Mother/friend_____ Phone _____

Father/friend_____Phone_____

INSURANCE INFORMATION (If applicable)

Employer _____ Occupation _____

Insured's Name (if not you) _____DOB (if not you) _____

Insurance ID #_____ Group #_____

Insurance Company _____ Authorization Code _____

Amount of co-pay _____ Deductible _____ Deductible Met? __Yes __No

Fee for 50 minute session $130

1. What brings you in for counseling?

2. How will you know if things are improving?

3. Please list any medications you are currently taking.

Signature of guardian if client is below 18 years old
Client(print)_____ Date _____

Client (sign):_____ Date:_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle) Poor, Unsatisfactory, Satisfactory, Good, Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □Yes

6. Do you regularly use alcohol? □ No □ Yes In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use? □ Daily □ Weekly

□ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes

□ Rarely Have you had them in the past? □ Frequently □ Sometimes □ Rarely

□ Never

9. Are you currently in a romantic relationship? □ No □ Yes If yes, how long have you been in this relationship? _____ On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors? Please list:

_____

Have you or your child ever experienced:

Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes times per week?_____

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes If yes, who is your current employer/position? _____ If yes, are you happy at your current position? _____ Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith? _____ If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that applies and list family member, e.g., Sibling, Parent, Uncle, etc.)

Family Member with any of the following.

Depression: □ No □ Yes Bipolar Disorder: □ No □ Yes

Anxiety Disorders: Panic Attacks: □ No □ Yes Schizophrenia: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes Eating Disorders: □ No □ Yes

Learning Disabilities: □ No □ Yes Trauma History: □ No □ Yes

Suicide Attempts: □ No □ Yes

OTHER INFORMATION:

What do you consider to be your strengths?

_____
_____
_____
_____

What do you like most about yourself?

_____
_____
_____

What are effective coping strategies that you've learned?

_____
_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Signature

Client (print) _____ Date:_____

Client (signature)_____ Date:_____