JOURNEYS
COUNSELING CENTER

668 N. Orlando Ave. Ste. 208
Maitland, FL. 32751
407-951-8829

GENERAL INFORMATION

Full Name: _____
First Middle Last

Name you prefer: _____ Age: _____ Date of Birth:_____

Referred by_____ May we thank them? □ Yes □ No

Race/Ethnicity: _____ Sex: □ Male □ Female

Briefly describe your cultural background: _____

_____

Briefly describe your faith background if any:

_____

_____

CONTACT INFORMATION

Address: _____
Street City State Zip

Email address: _____ Is it alright to contact you here? □Y □N

Phone: _____ _____ (Please circle preference)
Home Cell

Emergency Contact Name:_____ Phone: _____

EMPLOYMENT INFORMATION

Employer_____ How long have you been there? _____

Occupation: _____ Avg. hrs. worked per week: _____

Average Annual Salary: □ $0 - $10,000 □ $10,000 - $20,000 □ $20,000 - $40,000
□ $40,000 - $50,000 □ $50,000 - $60,000 □ $60,000 - $80,000
□ $80,000 - $100,000 □ More than $100,000

EDUCATION INFORMATION

Last year of school completed: □ 9 □ 10 □ 11 □ 12 □ GED □ College □ Graduate □ Post Graduate

Are you currently in school: □ Yes □ No. If yes, what level: _____

Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: □ Single □ Dating □ Engaged □ Partnership □ Married

□ Separated □ Divorced □ Widowed If Married, how long: _____

If Previously Married, how many times: _____ For Your Partner: _____

With whom do you currently live (*check all that apply*): □ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s) □ Boyfriend □ Girlfriend □ Roommate □ Other: _____

Who do you go to for advice or emotional support? _____

What is their relationship to you? _____

CHILDREN

List Your Children (Living or Deceased):

Name	Current Age or Year of Death	Relationship to you (adopted, step, etc)	Living w/ You (yes/no)	Briefly Describe Him/Her

Have You Ever Placed a Child for Adoption: □ Yes □ No. If Yes, when: _____

Have You Ever Had a Miscarriage or Medical Abortion: □ Yes □ No. If Yes, when: _____

_____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and any other family members who affected you positively or negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(Parent, Sibling, etc)*	Occupation	Briefly Describe Him/Her

MEDICAL INFORMATION

Name of Physician: _____

List any conditions, illnesses, surgeries, hospitalizations, traumas or related treatments you have experienced and the year they occurred: _____

_____

List of current medications/dosage:	Prescribed For:
_____	_____
_____	_____
_____	_____
_____	_____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, and/or in the Recent Past:

Headaches	□ Past □Present	Difficulty Breathing	□ Past □Present
Change in Appetite	□ Past □Present	Hearing Voices	□ Past □Present
Dizziness	□ Past □Present	Sleep Trouble	□ Past □Present
Tension	□ Past □Present	Intestinal Trouble	□ Past □Present
Fatigue	□ Past □Present	Seeing Things	□ Past □Present
Stomach Trouble	□ Past □Present	Trouble Relaxing	□ Past □Present
Rapid Heart Rate	□ Past □Present	Hearing Noises	□ Past □Present

CURRENT STATUS

Stress	□ Past □Present	Sadness	□ Past □Present
Anxiety	□ Past □Present	Depression	□ Past □Present
Panic	□ Past □Present	Death of a loved one	□ Past □Present
Loss of Control	□ Past □Present	Shame	□ Past □Present
Irritability	□ Past □Present	Grief	□ Past □Present
Anger	□ Past □Present	Guilt	□ Past □Present
Aggressiveness	□ Past □Present	Recent Loss	□ Past □Present
Nervousness	□ Past □Present	Sexual Abuse	□ Past □Present
Bad Dreams	□ Past □Present	Emotional Abuse	□ Past □Present
Racing Thoughts	□ Past □Present	Verbal Abuse	□ Past □Present
Impulsive Behavior	□ Past □Present	Physical Abuse	□ Past □Present
Compulsive Behavior	□ Past □Present	Trauma	□ Past □Present
Rigid Behavior	□ Past □Present	Terminal Illness	□ Past □Present
Unwanted Thoughts	□ Past □Present	Marriage	□ Past □Present
Unwanted Memories	□ Past □Present	Pregnancy	□ Past □Present
Fears	□ Past □Present	Infertility	□ Past □Present
Shyness	□ Past □Present	Abortion	□ Past □Present
Loneliness	□ Past □Present	Career Choices	□ Past □Present
Inferiority	□ Past □Present	Finances	□ Past □Present
Defective Feelings	□ Past □Present	Trouble with Job	□ Past □Present
Indecisive	□ Past □Present	Legal Matters	□ Past □Present
Difficulty Focusing	□ Past □Present	Drug Use	□ Past □Present
Forgetfulness	□ Past □Present	Alcohol Abuse	□ Past □Present
Sexual Problems	□ Past □Present	Eating Issues	□ Past □Present
Hopelessness	□ Past □Present	Relational Issues	□ Past □Present
Vulnerability	□ Past □Present	Other	□ Past □Present
Apathy	□ Past □Present		

LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below: (1 = Very Little Distress; 10 = Extreme Distress) 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

Are you currently experiencing any suicidal thoughts: □ Yes □ No

Have you experienced them in the past: □ Yes □ No

Have you ever attempted suicide: □ Yes □ No. If Yes, when and how: _____

_____

Have any of your friends or family ever committed or attempted suicide: □ Yes □ No
If Yes, who and when:

_____

_____

PRESENTING ISSUES AND GOALS

What is it that you hope to address in Counseling? (i.e. Problems, concerns, etc)

_____

_____

What do you hope to gain or change by coming for counseling?

_____

_____

What is the catalyst for choosing to come to counseling at this time?

_____

PRIOR COUNSELING EXPERIENCE

List any previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care you have previously received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____

Reason: _____

Therapist: _____ Location: _____ Dates: _____

Reason: _____

Terms of Service

In addition to the counseling session fees, it is our practice to charge a fee of $150.00 per hour on a prorated basis for other professional services you may require, such as report writing, telephone conversations lasting longer than ten (10) minutes, attendance at meetings or consultations with other professionals which you have authorized, preparations of records or treatment summaries, or the time required to perform any other service which you may request of me. In some circumstances, you may be involved in a litigation, which may require my participation. **You will be required to pay for the professional time required, EVEN if I am compelled to testify by another party. (Because of the complexity and difficulty of legal involvement, I charge $250.00 per hour for preparation for travel from my office and back, and for my time waiting for and attending any legal proceeding).**

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. ***I further understand that without 24-hour notice of intention to cancel, I will be charged the full fee for service.***

Signature **Date**