CBC

Case records are confidential. No one is permitted to see your record without your written permission.

Biographical Information:

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Telephone: Hm _____ Wk _____ Cell _____

Social Security Number: _____ Age: _____ D.O.B. _____

Sex: Male ___ Female ____ Religious Affiliation: as a child_____ adult _____

Marital Status: Single ____ Divorced ____ Separated ____ Married ____ Engaged _____ Widowed _____

Number of Marriages and Length of Each: _____
_____
_____

Name of Emergency Contact:
_____ Phone: _____

_____ Phone: _____

Type of problem that brought you to CBC: (circle)
Home School Job Premarital Marital Sexual Emotional

Briefly describe your reason for seeking help: _____
_____
_____

How did you hear about CBC? _____

Family Information:

Immediate Family Members (spouse/Children)			Family of Origin (parent/sibling)		
Name	Age	Relationship	Name	Age	Relationship

Does anyone in your family suffer from alcoholism, eating disorder, depression or anything that might be considered a mental disorder? Please explain.

_____
_____
_____

Medical/Emotional History:

Physician's Name: _____ Phone: _____
Date of last physical: _____
Please list any medical treatments & operations within the last year: _____
_____
_____

Please list current illnesses: (allergies, ulcers, tensions, back problems, skin disorders etc) _____
_____
_____
_____

Please list all medications you are currently taking: _____
_____
_____

Past Counseling: (circle) Yes No (if yes please list dates/therapists/address)
_____
_____

Have you ever been hospitalized for emotional/eating disorder or chemical dependency etc?
Yes No (if yes please list dates/names/hospitals etc)
_____
_____
_____

Past or current (please indicate) suicidal or homicidal ideation or attempts? Explain. _____
_____
_____
_____

Past or current (please indicate) physical or sexual abuse? Please explain briefly. _____
_____
_____
_____

Please provide us with a brief work history starting with current employer:
Employer: _____ Occupation: _____ length: _____
Employer: _____ Occupation: _____ length: _____
Employer: _____ Occupation: _____ length: _____

Employer: _____ Occupation: _____ length: _____

May we contact you at your work? (circle) Yes No May we leave a message? (circle) Yes No

Education Level: _____

Case records are confidential. No one is permitted to see your record without your written permission.

Check any of the following that apply to you:

	Headaches		Dizziness		Fainting Spells
	Palpitations		No Appetite		Bowel Disturbances
	Fatigue		Insomnia		Nightmares
	Take Sedatives		Problem with Alcohol		Tense Feelings
	Feel Panicky		Tremors		Depressed
	Thoughts of Suicide		Drugs		Unable to relax
	Sexual Problems		Difficulty having fun		Difficulty making friends
	Feel lonely		Difficulty making decisions		Difficulty keeping a job
	Inferiority Feelings		Poor Home Environment		Financial Problems
	Anger		Legal Matters		Education
	Children		Self Control		Memory
	Career Choices		Being a Parent		Easily Distracted
	Binge/Vomit/Laxatives		Lose Time		Hyperactive
	Unable to Sit Still		Compulsive Behavior		Spouse Issues
	Thoughts		Divorce		Separation

Is there anything else you might want the therapist to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____

CBC

Case records are confidential. No one is permitted to see your records without your written permission.

Payment Information for Minors:

Name of Client (minor): _____

Responsible Party: _____ Relationship to client: _____

Address: _____ City: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

AS LEGAL GAURDIAN OF SAID MINOR, I VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND THAT I TAKE FULL RESPONSIBILITY FOR ANY AND ALL FEES INCURRED AS A RESULT OF COUNSELING.

_____ _____

Signature of Responsible Party Date

CBC

Case records are confidential. No one is permitted to see your records without your written permission.

MARKETING INFORMATION

How did you hear about CBC?

_____
_____
_____
_____

What prompted you to choose CBC?

Price ____ Location ____ Friend _____ Philosophy of Counseling _____

Reputation of Center _____ Reputation of Counselor _____ Other _____

May we contact your minister about our services? (counseling, groups, seminars, etc) Yes No

Name of Church: _____
Church Address: _____
Minister's Name: _____
Church Phone: _____

What type of seminars interests you?

Relationships	Depression	Gender Issues
Anger	Basics in Counseling	Sexual Abuse
Marriage	Spiritual Growth	Premarital
Parenting	Other _____	