

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

## BIOGRAPHICAL INFORMATION:

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ Social Security No. \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  male  female

Marital Status:  Single  Divorced  Separated  Married  Engaged  Widowed

Number of Marriages & length of each: \_\_\_\_\_

Religious affiliation: as a child \_\_\_\_\_ as an adult \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact you at work?  yes  no May we leave messages for you at work?  yes  no

Name of person(s) to contact in case of an emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of problem that brought you to CBC:

Home  School  Job  Pre-Marital  Marital  Sexual  Emotional

Briefly describe your reason for seeking help: \_\_\_\_\_

How did you hear about CBC? \_\_\_\_\_

Immediate Family Members (Spouse, Children)			Family of Origin (Parents, Siblings)		
Name	Age	Relationship	Name	Age	Relationship

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

\_\_\_\_\_

\_\_\_\_\_

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## Medical/Emotional History

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Physical: \_\_\_\_\_

Please list any medical treatments & operations within the last year:

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

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Please list any prescription medications you are presently taking:

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Past Counseling?  Yes  No (If yes, please list therapists, dates, and address.)

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Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency, etc.?

Yes  No

(If yes, please list hospital, doctor's name and dates with a brief explanation.)

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Past/current suicidal or homicidal ideations/attempts? Please explain briefly.

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Physical/sexual abuse? Please explain briefly.

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Check any of the following problems 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 problems
Thoughts	Divorce	Separation

### Payment Information for minors:

Responsible Party:	Relationship to client:	
Address:	City:	Zip:
Phone: (Hm)	(Wk)	Social Security#:

As legal guardian of said minor, I verify that the above information is accurate and that I take full financial responsibility for any and all fees incurred as a result of counseling.

\_\_\_\_\_  
(Signature of Responsible Party)

\_\_\_\_\_  
(Date)

## MARKETING INFORMATION

How did you hear about CBC?

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What prompted you to choose CBC?

- |   |   |
|---|---|
| <input type="checkbox"/> Price                | <input type="checkbox"/> Location                 |
| <input type="checkbox"/> Friend               | <input type="checkbox"/> Philosophy of Counseling |
| <input type="checkbox"/> Reputation of Center | <input type="checkbox"/> Reputation of Counselor  |
| <input type="checkbox"/> Other _____          |   |

May we contact your minister about our services? (Counseling, Groups, Seminars, etc.)  Yes  No

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Name of Church you attend:

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Church Address:

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Minister's name:

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Church Phone:

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What types of seminars interest you?

- |  |   |
|--|---|
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Gender Issues | <input type="checkbox"/> Basics in counseling |
| <input type="checkbox"/> Anger         | <input type="checkbox"/> Sexual Abuse         |
| <input type="checkbox"/> Marriage      | <input type="checkbox"/> Spiritual Growth     |
| <input type="checkbox"/> Pre-Marriage  | <input type="checkbox"/> Parenting            |