Meridian Counseling Services

13210 SE 240th St. Suite A5, Kent, WA, 98042

Please complete all information on this form and bring it to your first counseling session

Demographics

Today's Date _____

Name _____ Date of Birth _____

Home Phone _____ May I leave messages on this phone? ( ) y ( ) n

Work Phone _____ May I leave messages on this phone? ( ) y ( ) n

Cell Phone _____ Email _____

Address _____

City _____ Zip Code _____

Emergency Contact _____ Relationship to You _____

Phone _____

Sexual Orientation ( ) Heterosexual ( ) Homosexual ( ) Bisexual ( ) Other ( ) Prefer not to answer

What gender do you identify with? ( ) Male ( ) Female ( ) Other

Who referred you? (if applicable) _____

Relationship Status

Are you: Single ( ) Dating ( ) Married/Partnered ( ) Divorced/Separated ( ) Widowed ( )

If applicable, describe your relationship with your current partner (place an "X" on the line below.)

Major Problems ( ) Minor Problems ( ) Satisfactory ( ) Very Satisfactory ( )

How long have you been in the relationship? _____

Have you had any prior marriages? ( ) y ( ) n If so, how many? _____

For how long were you married? _____

Children

Please list any children you have and Indicate if they live with you part time, full-time or not at all:

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

Do they live this you? _____ P/T _____ F/T _____ Not at all _____

Educational/Occupational/Legal History

What is your highest educational level attained? _____

Did you attend college? ( ) y ( ) n If so, what was your major? _____

Are you currently: ( ) working ( ) not working

What is your occupation? _____

Do you have any pending legal issues? ( ) y ( ) n

Therapy Needs

List the top 3 problems for which you wish to be seen and/or would like to work on:

1. _____
2. _____
3. _____

In the past, what has been helpful to you in dealing with these problems?

_____

_____

What are your goals for treatment?

_____

_____

Therapeutic History

Have you ever been given a mental health diagnosis in the past from a mental health professional?

( ) y ( ) n If so, what was the diagnosis? _____

Have you ever had counseling before? If so, when and with whom?

_____

Was it helpful?_____

Are you currently taking psychiatric medication? ( ) y ( ) n If yes, please list:

_____

_____

Have you taken psychiatric medication in the past? ? ( ) y ( ) n If yes, please list:

_____

Have you ever attempted suicide in the past? ( ) y ( ) n If so, when? _____

Are you currently suicidal? ( ) y ( ) n If so, do you have a plan? _____

Medical History

Are you currently under treatment for any medical condition? ( ) y ( ) n If so, please list:

_____

_____

Are you taking medication for this? If so, what?

_____

Symptoms: What symptoms contributed to you coming in today? (Check all that apply)

Appetite

( ) overeating ( ) voluntary vomiting ( ) binge eating
( ) weight gain ( ) weight loss ( ) recent appetite changes

Sleeping & Energy

( ) difficulty falling asleep ( ) difficulty getting up ( ) Excessive energy
( ) difficulty staying asleep ( ) nightmares ( ) fatigue/loss of energy
( ) sleeping too much ( ) decreased need for sleep ( ) cannot quiet mind

Relationships

( ) trust issues ( ) family issues ( ) parenting/step parenting concerns
( ) communication issues ( ) conflict/fighting ( ) boundary issues
( ) infidelity ( ) codependency ( ) controlling behavior
( ) role expectations ( ) abusive relationship ( ) anger issues
( ) emotional intimacy concerns ( ) sexual intimacy concerns ( ) low self esteem/insecurity
( ) obsessing about relationship ( ) dependency issues ( ) difficulty saying "no"

Mood

( ) depression ( ) feelings of guilt ( ) panic attacks
( ) mania ( ) feeling numb ( ) hopelessness
( ) mood changes ( ) irritability ( ) helplessness
( ) anxiety ( ) fear ( ) sadness

Behavior

( ) avoidance ( ) fear of objects/situations ( ) increased isolation
( ) compulsive behavior ( ) repetitive behaviors ( ) impulsive behavior
( ) difficulty staying on task ( ) loss of interest in activities ( ) Manipulation
( ) self harming behavior ( ) aggressive behavior ( ) using alcohol/drugs

Cognition

( ) thoughts of self-harm ( ) racing thoughts ( ) frequent worries
( ) thoughts of harming others ( ) persistent disturbing thoughts ( ) critical thoughts of self
( ) obsessing ( ) hyper vigilance ( ) intrusive memories
( ) flashbacks ( ) feeling detached from self ( ) odd thoughts/behaviors
( ) questioning what is real ( ) hearing voices ( ) memory issues
( ) large gaps in memory ( ) difficulty problem solving ( ) difficulty concentrating

Other

( ) concerns about sexuality ( ) past trauma ( ) current trauma
( ) sexual abuse ( ) problems with school ( ) problems with work
( ) housing problems ( ) financial difficulties

Self Care/Social Assessment

Do you exercise? ( ) y ( ) n Frequency? _____

How many meals per day do you eat? _____

Average hours of sleep per night: _____

What hobbies or leisure activities do you do ? (if any) _____

_____

Do you spend time with friends or a community? _____

Who do you count on for support? _____

_____

What brings you comfort? _____

What are your strengths? _____

_____

_____

Addiction Issues:

Have you ever been treated for alcohol or drug use/abuse? ( ) y ( ) n If yes, where were and when?

_____

Do you think you may have a problem with alcohol or drug use? ( ) y ( ) n

How many alcoholic drinks do you consume each week? _____

In the past three months, what is the largest number of alcoholic drinks you consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) y ( ) n

Have people ever told you that you should cut down on your drinking or drug use? ( ) y ( ) n

Have you ever felt bad or guilty about your drinking or drug use? ( ) y ( ) n

Do you currently use marijuana? ( ) y ( ) n

If so, how often? _____

Do you use other non-prescription drugs? ( ) y ( ) n If so, what? _____

Do you view porn? ( ) y ( ) n If so, what is the frequency? _____

Outside of work, how many hours per day do you spend in front of a screen? _____

Other addiction issues- check all that may apply either now or in the past:

Gambling ( ) y ( ) n	Work ( ) y ( ) n	Pornography ( ) y ( ) n
Food ( ) y ( ) n	Prescription pills ( ) y ( ) n	Social Media ( ) y ( ) n
Video games ( ) y ( ) n	Sex/Relationship addiction ( ) y ( ) n	
Online Hook-ups ( ) y ( ) n	Other _____	

Spiritual Assessment:

Do you have a belief in God or a Higher Power? ( ) y ( ) n

Are you affiliated with a religion or spiritual group? ( ) y ( ) n Which one? _____

Do you attend regularly ( ) y ( ) n Is this a positive experience for you? _____

Do you have any spiritual concerns you would like to explore in therapy? ( ) y ( ) n

If so, what are they? _____

_____

Do you want prayer to be part of your therapy process? ( ) y ( ) n ( ) undecided