

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 with you? _____ P/T _____ F/T _____ Not at all _____

Name _____ Age _____

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

Name _____ Age _____

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

Name _____ Age _____

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

Name _____ Age _____

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

Name _____ Age _____

Do they live with 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

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> overeating | <input type="checkbox"/> voluntary vomiting | <input type="checkbox"/> binge eating |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> weight loss | <input type="checkbox"/> recent appetite changes |

Sleeping & Energy

- | | | |
|--|---|---|
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> difficulty getting up | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> difficulty staying asleep | <input type="checkbox"/> nightmares | <input type="checkbox"/> fatigue/loss of energy |
| <input type="checkbox"/> sleeping too much | <input type="checkbox"/> decreased need for sleep | <input type="checkbox"/> cannot quiet mind |

Relationships

- | | | |
|---|---|--|
| <input type="checkbox"/> trust issues | <input type="checkbox"/> family issues | <input type="checkbox"/> parenting/step parenting concerns |
| <input type="checkbox"/> communication issues | <input type="checkbox"/> conflict/fighting | <input type="checkbox"/> boundary issues |
| <input type="checkbox"/> infidelity | <input type="checkbox"/> codependency | <input type="checkbox"/> controlling behavior |
| <input type="checkbox"/> role expectations | <input type="checkbox"/> abusive relationship | <input type="checkbox"/> anger issues |
| <input type="checkbox"/> emotional intimacy concerns | <input type="checkbox"/> sexual intimacy concerns | <input type="checkbox"/> low self esteem/insecurity |
| <input type="checkbox"/> obsessing about relationship | <input type="checkbox"/> dependency issues | <input type="checkbox"/> difficulty saying "no" |

Mood

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> depression | <input type="checkbox"/> feelings of guilt | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> mania | <input type="checkbox"/> feeling numb | <input type="checkbox"/> hopelessness |
| <input type="checkbox"/> mood changes | <input type="checkbox"/> irritability | <input type="checkbox"/> helplessness |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> fear | <input type="checkbox"/> sadness |

Behavior

- | | | |
|---|---|--|
| <input type="checkbox"/> avoidance | <input type="checkbox"/> fear of objects/situations | <input type="checkbox"/> increased isolation |
| <input type="checkbox"/> compulsive behavior | <input type="checkbox"/> repetitive behaviors | <input type="checkbox"/> impulsive behavior |
| <input type="checkbox"/> difficulty staying on task | <input type="checkbox"/> loss of interest in activities | <input type="checkbox"/> Manipulation |
| <input type="checkbox"/> self harming behavior | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> using alcohol/drugs |

Cognition

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

Other

- | | | |
|---|---|---|
| <input type="checkbox"/> concerns about sexuality | <input type="checkbox"/> past trauma | <input type="checkbox"/> current trauma |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> problems with school | <input type="checkbox"/> problems with work |
| <input type="checkbox"/> housing problems | <input type="checkbox"/> 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