The Gateway Center for Counseling & Recovery, LLC

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Name: ____ Date:_______________
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age(s):

____

____

Address *(Street and Number)*:

____

____
(City) (State) (Zip)

Home Phone: ________________________ May we leave a message? □Yes □No

Cell: ______________________________ May we leave a voicemail and/or text message? □Yes □No

Work Phone: ________________________May we leave a message? □Yes □No

E-mail: ____ May we email you? □Yes □No

*Please note: Electronic correspondence is not considered to be a confidential medium of communication. As such, no clinical information should be discussed. (Use only for generic communication, e.g. change in appointments.)

Emergency Contact regardless if a release has been signed:

Name: _________________________________ Relationship:__________________________

Phone #: ________________________________

Referred by (if any):

Name:___________________________________ May we contact this person? _______________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner/facility:

____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list:

____

____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (Please circle)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in: __________________________________

4. Please list any difficulties you experience with your appetite or eating patterns.

____

____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No

□ Yes

If yes, for approximately how long? _________________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes

If yes, when did you begin experiencing this? ____________________________

7. Are you currently experiencing any chronic pain?

□ No

□ Yes

If yes, please describe? ____________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, # per day _____ # per week _____ Binge drinking? □ No □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Types of illicit drugs taken the past year and how frequent?

____

____

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:

____

____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Family Member
Alcohol/Substance Abuse	______________________________
Anxiety	______________________________
Depression	______________________________
Domestic Violence	______________________________
Eating Disorders	______________________________
Obesity	______________________________
Obsessive Compulsive Behavior	______________________________
Schizophrenia	______________________________
Suicide Attempts	______________________________

ABUSE HISTORY:
Have you ever been a victim of Sexual, Emotional and/or Physical Abuse? If so, by whom and for how long?

____

____

____

LEGAL HISTORY:
Have you ever been arrested? ____________________

What charges and when? ____

____

Current Probation/Parole Officer:______________________________________

Officer's Location:____

Officer's Phone # ____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes Student? ________

If yes, name of your employer/school:

____

____

Do you enjoy your work/school? Is there anything stressful about your job/school?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

____

____

____

4. What do you consider to be some of your weakness?

____

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

____

___________________________________ Date:___________

Client Signature

____

Client Print Name

If Client is a Minor:

____________________________________ Date:____________

Minor Signature

____

Minor Print Name

____________________________________ Date:____________

Parent or Guardian Signature

____________________________________ Date:____________

Parent or Guardian Print Name

___________________________________ Date:____________

Clinician Signature