Heartprints Counseling LLC

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Initial Contact Information *(to be completed by client 13 years of age and older with parent input as needed; for clients 12 years and under, to be completed by parent with child's input as needed)*

Date_____

Client's Legal Name _____DOB_____Age_____
Preferred Name and/or Nicknames_____Gender_____
Guardian(s) or Spouse, if applicable_____
Address_____

_____

How did you hear about Heartprints?

Referred by my doctor/clinic _____ Psychology Today
Referred by my youth pastor/church _____ Found on an Internet search
Referred by a friend/family member _____ Other_____

If applicable, may I thank whoever referred you? Yes, that would be ok No, thank you

Do you wish to receive an email reminder of the appointment that may be added to your e-calendar? (Please understand this is not an encrypted email, and as with most electronic information, may not be secure)

Y N E-mail_____

Please do not list any phone number unless it is permissible to leave a message at the number provided.

Ok to text? (Note: Texting/messaging may not be secure forms of communication.)

Y N Client's Primary Number_____
Y N Caregiver's Primary Contact Number (if applicable)_____
Y N Caregiver's Alternative Contact Number (if applicable)_____
House Phone Number_____

Please list an emergency contact person and their phone number:

_____

Name Relationship Contact number

*Presenting Concern: What brings you in today?*_____

_____
_____
_____
_____
_____
_____
_____

*What are your goals for our time together?*_____

_____
_____

*Any specific/general concerns or questions about counseling, the counseling process, or the counselor?*_____

How long do you think therapy should last? _____
*What do you think therapy is about?*_____

Medical Information

Who is your PCP (Primary Care Provider/Doctor)?_____
*Date of last appointment with your PCP?*_____ *PCP's phone number?*_____
Any current medical problems (please include issues like regular headaches, constipation, & diarrhea)?

*History of medical problems (allergies, surgeries, broken bones, hormonal imbalances, medically necessary hospitalizations, etc…)*_____

*If applicable, age at first period*_____ *Are they regular?* Y N
What vitamins and/or medications do you regularly take? Please include birth control, if applicable.
Vitamin/Medication Reason for Taking Dosage Amount Prescriber Duration of time

*Please list any prior psychotropic medications used in the past not listed above*_____

Do you smoke or vape? N Y *If so, how frequently?*_____
Not anymore *If so, for how long did you smoke/vape for previously?*_____
*How much caffeine do you have on a given day? (Please include tea, coffee, soda, energy drinks, etc…)*_____

*If any, please list dietary/medical food restrictions*_____

Legal Information

Have you ever been arrested, been involved in a CPS (Child Protective Services) investigation, filed a complaint against a professional, or been involved in a court case including custody issues?
N Y *If yes, please explain circumstances:*_____

Employment N/A I am currently unemployed and not attending school.
*Where do you work?*_____ I am a full-time student I am a part-time student
*How long have you had this job?*_____
If applicable, please list your last 2 employers and duration of time there not including your current work:

_____

_____

Academic Information *Please list schools attended:*
*Elementary:*_____

_____

*Middle School:*_____

_____

*High School:*_____

_____

*Beyond High School:*_____

_____

*Current Grade*_____ *Current School*_____ *School Counselor*_____
*If known, overall GPA*_____ *If known, current GPA*_____
If applicable, please list any suspensions or expulsions and their circumstances: N/A

_____

_____

_____

Making friends is: Easy Can be both easy or hard depending on circumstances Hard
Keeping friends is: Easy Can be both easy or hard depending on circumstances Hard

Personal Information
*Where were you born?*_____ *How many times did you move between your birth and your current age (or 18-whichever comes first)?Please list location also:*_____

_____

_____

_____

*What is your religious affiliation, if any?*_____
*If applicable, what church/youth group do you attend?*_____
*What is your race and/or ethnicity?*_____
What pronouns do you prefer: She/her/hers They/Them/Their He/Him/his
What is your orientation? N/A _____
Do you have concerns related to your orientation or gender? N/A Prefer not to answer
Not at all Little Somewhat A lot Unsure
Are you currently in a relationship? N/A Yes No *If yes, how long have you been together?*_____
Please list history of serious and/or intimate relationships: N/A
Name *Duration of relationship*

_____

_____

_____

Please include any values, traditions, customs, or cultural practices that are important to you that would be helpful for me to know? _____

_____

_____

Have you ever tried to kill or seriously injure someone else? Y N *If yes, please explain the circumstances*:

Have you ever intentionally destroyed property when upset or calm? (Examples: holes in wall, broken windows) Y N *If yes, please explain circumstances:*

Have you ever verbally threatened anyone directly or indirectly? Y N *If yes, please explain:*

Have you ever run away from home? Y N *If yes, please explain:*

Do you experience any nighttime bedwetting or accidental bowl movements/urination during the day? Y N *If yes, please describe:*

Have you ever started a fire that got out of control, or was in an unsafe environment, or put people or property at risk? Y N If yes, please explain circumstances:

Has anyone in your family ever tried to kill themselves or committed suicide? Y N
If so, whom & when?

Have you seen other counselors/therapist prior to today? Y N
If yes, please complete
Name of Therapist/Counselor *Starting/ending date* *Effectiveness*

Please list any mental health diagnosis in the family tree: (Examples: Bi-Polar, ADHD, Depression, Anxiety, Eating Disorder, Schizophrenia, Personality Disorders, etc…)
Family Member Relation Diagnosis Medicated?

Anything I should or should not repeat from prior therapy experience?

Have you ever hurt yourself on purpose? Y N
If yes, approximately how many times?
Have you tried to kill your self? Y N

*If yes, how many times have you tried to kill yourself?*_____
If yes, in the last 6 months? Y N *If yes, in the last month?* Y N
Do you have any phobias? Y N *If yes, please list:*_____
Have you ever been hospitalized for mental health reasons? N Y *If yes, please explain circumstances:*_____

_____

_____

Have you experienced a traumatic event where you felt like you or someone's safety was at risk? Y N
If so, does this event cause disruption to you regularly through dreams, body reactions, memories, or flashbacks? Y N
If any, what significant losses/deaths have you experienced? N/A _____

_____

_____

*How many hours of sleep do you typically get a night?*_____
*How many hours of sleep would you like to get a night?*_____
*What time do you normally go to sleep?*_____ *What time do you normally wake up?*_____
Do you regularly take naps? Y N
How often are you tired during the day? Never Rarely Occasionally Regularly Often
Are their electronic devices (i.e. TV, laptop, phone, kindle, tablet, gaming system, etc…) in the room you sleep in? Y *N If yes, please list*:_____

_____

*How often do you generally wake up at night?*_____
*Do you ever have anxiety around eating food?*_____
*How many meals/snacks do you generally eat in a given day?*_____
Do you regularly experience feeling sick, guilty, or nauseous after eating? Y N
Have you ever experienced any of the following? Please check all that apply If yes, please explain:

- ☐ Domestic Violence_____
- ☐ Watching someone use drugs/alcohol when you were a minor_____
- ☐ Live with someone who struggles with their mental health_____
- ☐ A divorce or parental separation_____
- ☐ A household member arrested and/or taken to jail/prison_____
- ☐ An abortion_____
- ☐ Giving up a child for adoption_____
- ☐ Being adopted_____
- ☐ Foster care_____
- ☐ Homelessness_____
- ☐ Feeling outside your body_____
- ☐ Bullying_____
- ☐ Exposure to pornographic material_____
- ☐ Assault in any form_____
- ☐ Seeing or hearing things that no one else does_____
- ☐ Picking at skin/fingers, nail biting, lip/cheek chewing to the point of bleeding (circle applicable)
- ☐ Repetitive moments, twitching, tics, fainting or seizures (circle applicable)

Are you open to family therapy? Yes No Maybe in the future but not for now

*Anything else I should know?*_____