

CONNECTION COUNSELING
ADULT REGISTRATION FORM

CLIENT INFORMATION

Name: _____ Date of first appt: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Age: _____ Date of Birth: _____

Single Married Separated Divorced Widowed

Dates of Marriage(s)/Divorce(s): _____

Children: Name(s) & Age(s): _____

Client Social Security # _____

Client Occupation: _____ Employer: _____

Employer Phone: _____ Typical Work Schedule: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Occupation: _____ Employer: _____

Church Affiliation (if any): _____

Additional phone numbers: _____

May we call you at home? Yes No

May we leave a message at your home? Yes No

May we leave a message on your cell phone? Yes No

In case of emergency, contact:

Name: _____ Relationship: _____

Home number: _____ Work number: _____

PREVIOUS COUNSELING OR THERAPY

Please list any inpatient therapy and dates: _____

Please list any outpatient therapy and dates: _____

How were you referred to Connection Counseling?

Family/Friend Pastor/Elder Employer Web search Advertising Other

What were the primary concerns or problems that led you to make an appointment?

MEDICAL/HEALTH HISTORY

Physician's Name: _____ Physician's Phone: _____

Date of last complete physical: _____ Date of last visit: _____

Current Medications: _____

Health Problems (past and current): _____

Major surgeries (include year): _____

Allergies: _____

Sleep patterns: _____ Changes? _____ Height: _____ Weight: _____

Eating patterns: _____ Changes? _____

Any significant weight gain/loss? _____

Alcohol, drug, tobacco use (past & present): _____

Caffeine (amount used daily): _____

For Women:

Any problems with menstrual cycle? _____

Number of Pregnancies: _____ Live Births: _____

Family health history (immediate family members):

ADD/ADHD _____

Depression/Anxiety: _____

Personality/Mood Disorders: _____

Suicide/Suicide attempts: _____

Alcohol/Drug addiction and treatment: _____

Sexual addiction and treatment: _____

Hereditary disease (if applicable): _____

CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU PRESENTLY OR IN
THE LAST 60 DAYS

- | | | |
|---|--|--|
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Difficulties with school (past or present) |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Feeling irritable/on edge | <input type="checkbox"/> Full of energy |
| <input type="checkbox"/> Trouble getting to sleep | <input type="checkbox"/> Angry Outbursts | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Waking up during the night | <input type="checkbox"/> Restless, tense | <input type="checkbox"/> Unable to keep a job |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Excessive drinking |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Unable to have fun | <input type="checkbox"/> Frequent sweating | <input type="checkbox"/> Excessive use of drugs |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Shaky hands | <input type="checkbox"/> Problems with children |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Dizzy, lightheaded | <input type="checkbox"/> Problems with parents |
| <input type="checkbox"/> Can't get going | <input type="checkbox"/> Nausea, stomach problems | <input type="checkbox"/> Excessive use of medication |
| <input type="checkbox"/> Loss of sexual interest | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Experiencing flashbacks |
| <input type="checkbox"/> Indecisive | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Lacking in motivation | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Disoriented |
| <input type="checkbox"/> Thoughts of hurting myself | <input type="checkbox"/> Chills or hot flashes | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Cold feet and hands | <input type="checkbox"/> Confusion regarding sexual preference |
| <input type="checkbox"/> Loss of meaning to life | <input type="checkbox"/> Constipation | <input type="checkbox"/> Engaged in alternate lifestyle sexually |
| <input type="checkbox"/> Lacking in confidence | <input type="checkbox"/> Muscles twitching | <input type="checkbox"/> Isolated |
| <input type="checkbox"/> Unresolved grief | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Detached |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Headaches | <input type="checkbox"/> Feeling out of control |
| <input type="checkbox"/> Avoid contact with friends | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Feeling like a disappointment |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Poor health | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Not enjoying usual activities | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Feel distant from God |
| <input type="checkbox"/> Feeling easily hurt | <input type="checkbox"/> Always worried | <input type="checkbox"/> Unable to experience God's love and forgiveness |
| <input type="checkbox"/> Tendency to put off doing things | <input type="checkbox"/> Avoiding crowds | <input type="checkbox"/> Confused about God |
| <input type="checkbox"/> Don't feel like being alone | <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Angry at God |
| <input type="checkbox"/> Losing weight | <input type="checkbox"/> Shy with people | <input type="checkbox"/> Disappointed in God |
| <input type="checkbox"/> Sleep whenever I can | <input type="checkbox"/> Racing thoughts | |
| <input type="checkbox"/> Frequent thoughts about death | <input type="checkbox"/> Frequently daydreaming | |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Worried about health | |
| <input type="checkbox"/> Troubled by childhood events | <input type="checkbox"/> Impatient with people | |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Feeling angry | |
| <input type="checkbox"/> Reliving past events | <input type="checkbox"/> Quick tempered | |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Feel like hurting someone | |
| <input type="checkbox"/> Quick to startle | <input type="checkbox"/> Feel like smashing things | |
| | <input type="checkbox"/> Can't make friends | |
| | <input type="checkbox"/> Can't handle money | |
| | <input type="checkbox"/> Difficulties at work | |