Welcome to Growth Space Counseling. Please fill this questionnaire out to the best of your ability. It helps me better get to know you and be of better help to you. If any questions make you uncomfortable or you are not ready to share about that, please just put a *. If you need addition space, please just use the back of the form and label it with the number it connects to.

GENERAL INFORMATION (*required*):

Name Date of Birth / / Gender:

Address

City State Zip Code

Best contact number: ( ) -

EMERGENCY CONTACT (*required*):

Name Relation Number

An additional form is provided to you (Release of Information) to consent to communication.

INSURANCE INFORMATION:

Primary Insurance Policy Holder Name

Policy Holder DOB / / Relationship

Policy Number Group Number

Policy Holder Address

City State Zip Code

SECONDARY INSURANCE INFORMATION:

Primary Insurance Policy Holder Name

Policy Holder DOB / / Relationship

Policy Number Group Number

Policy Holder Address

City State Zip Code

EAP PROVIDER:

Name: ___________________________ Phone: ___________________________

Authorization Number: __________________________

PAST MENTAL HEALTH TREATMENT (*required*)
Have you ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**
If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist? ☐ **YES** ☐ **NO**
If yes, when and for how long?

Have you ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**
If yes, when and for how long?

Current diagnoses (*physical and mental health*)

MEDICATIONS (*required*)

Name/dosage:	Reason for:	Side Effects/ Benefits:

Date of last visit to your primary care doctor for a wellness exam: ________________________

Date of last visit to your dentist for a cleaning: _______________________________________

Symptoms (*please check all that apply*)

☐ Depressed mood	☐ Excessive talking	☐ Unreasonable fear
☐ Lost or gained weight	☐ Racing thoughts	☐ Fear of social situations
☐ Not enough sleep	☐ Easily distracted	☐ Repetitive thoughts/behavior
☐ Too much sleep	☐ Over working yourself	☐ Upsetting memories
☐ Exhaustion	☐ Impulsive behavior	☐ Recent loss/grief
☐ Agitated	☐ See/hear things that are not real	☐ Work/school problems
☐ Never tired	☐ Suspect things may not be real	☐ Violent thoughts/behaviors
☐ Cannot concentrate	☐ Tense/unable to relax	☐ Self harm
☐ Afraid to leave home	☐ Excessive worry	☐ Anger outburst
☐ Inflated self esteem	☐ Panic attacks	☐ High-risk behavior
☐ Feel guilty or worthless	☐ Thoughts of death or suicide	☐ Financial problems
☐ Abusing substances	☐ Relationship issues	☐ Other (Please describe)

Danger to Self or Others (*required*)

Thoughts to Harm Self ☐Yes ☐No *If yes, please continue.*

Means (how do/did you plan on doing this):

Motivation (how likely are you to act on this): ☐not likely ☐likely ☐extremely likely

Have you ever acted on these thoughts? ☐Yes ☐No

If yes, when was the last time?__________ and how frequently does this occur?_____________

What are your motivations to prevent this from happening:

Thoughts to Harm Others ☐Yes ☐No *If yes, please continue.*

Means (how do/did you plan on doing this):

Motivation (how likely are you to act on this): ☐not likely ☐likely ☐extremely likely

Have you ever acted on these thoughts? ☐Yes ☐No

If yes, when was the last time?__________ and how frequently does this occur?_____________

What are your motivations to prevent this from happening:

Substance Use and Addictive Behaviors (*required*)

Alcohol usage (*amount/frequency*)

Marijuana usage (*amount/frequency*)

Other psychoactive drugs (*amount/frequency*)

Please include other abused activities if you feel this is an issue (video games, internet usage, gambling, sex, etc.) (*amount/frequency*)

Please include past addictions and method of treatment:

Socio-Cultural Information

Supports in my life include:

Cultural Identification (*please detail any communities you feel apart of*)

Family involvement (*please circle*)	Low	Medium	High
Friend involvement (*please circle*)	Low	Medium	High
Community involvement (*please circle*)	Low	Medium	High

Please include any additional notes you feel will help me get to know you better:

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Name (*printed*) Name of Client/Relationship to client if completed by guardian