KARITAS COUNSELING
ADULT CLIENT INFORMATION

Welcome to Karitas Counseling. We ask your cooperation in filling out this information. This is confidential and will assist your therapist in assessing your needs.

Today's Date _____________________ **Preferred Language** ☐ English ☐ Spanish

Client's Name: ____ **Birth Date** _________________ **Age** ________

Gender ☐ Male ☐ Female **Social Security #** __________________

Address ____
Street Address Apt # City State Zip Code

May we send mail at this address? ☐ Yes ☐ No

Home Phone (____) ________________________ May we leave a message? ☐ Yes ☐ No

Work Phone (____) ________________________ May we leave a message? ☐ Yes ☐ No

Mobile Phone (____) ______________________ May we leave a message? ☐ Yes ☐ No

Email __________________________________ May we email you? ☐ Yes ☐ No Please be aware that email may not be confidential.

Would you like a reminder for your appointments?
☐ **NO**, I will remember appointment. OR ☐ **YES**, send me reminder by ☐ Text to #________________________
☐ Call to #________________________ ☐ Email to ___________________________________

Who can we thank for referring you? ☐ Self ☐ Friend ☐ Family Member ☐ Medical Doctor: _________________
☐ Psychiatrist: _______________________________ ☐ Other: _______________________________

Emergency Contact: Who should we contact in case of an emergency?
Name: ____________________________ Relation: __________________ Phone: ____________________
Name: ____________________________ Relation: __________________ Phone: ____________________

Insurance Company Information:
Ins Co. Name:__________________________________ **Phone Number:**__________________________
Policy/ID:______________________________________ **Group Number:**__________________________

Policy Holder Information: (Complete section below IF policy holder is not client)
Policy Holder Name:__________________________________ **Date of Birth:**_____________________
Address:____ **Phone #:**__________________________
Employer:________________________ **Gender** ☐ Male ☐ Female **Social Security #** ________________________
Client relationship to Policy Holder: ☐ Spouse ☐ Child ☐ Other: _______________________

Secondary Insurance Company Information:
Ins Co. Name:__________________________________ **Phone Number:**__________________________
Policy/ID:______________________________________ **Group Number:**__________________________

Employee Assistance Program:
Ins Co. Name:__________________________________ **Phone Number:**__________________________
Authorization #:___________________ **# Sessions Authorized:**_______ **Expiration Date:**__________________

If no insurance or EAP, how will you pay for services? ____

Client or Authorized Person's Signature:
I authorize the release of any medical or other information necessary to process all insurance claims and authorize the use of this signature on all insurance submissions by Karitas Counseling. I authorize payment of medical benefits to Karitas Counseling and/or the provider.

Signature:____ Date:______________________

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PRESENTING PROBLEMS AND CONCERNS

Briefly describe the reason for your visit today: ____

____

____

Please check all of the behaviors and symptoms that you consider problematic:

☐ Sadness	☐ Sleep Problems	☐ Changes in appetite	☐ Inability to concentrate	☐ Panic Attacks
☐ Headache	☐ Suicidal thoughts	☐ Feelings of hostility	☐ Tension/Anxiety/worry	☐ Mood Swings
☐ Phobias	☐ Social Isolation	☐ Acts of Violence	☐ Strange Thoughts	☐ Crying Spells
☐ Boredom	☐ Hyperactivity	☐ Distractibility	☐ Loss of Pleasure/interest	☐ Hopelessness
☐ Self-harm	☐ Low Self-worth	☐ Thoughts of Death	☐ Other: ____________	☐ Loneliness
☐ Fatigue	☐ Hearing voices	☐ Alcohol/drug use	☐ Aggression/fights	☐ Paranoia

Are your problems affecting any of the following?

☐ Housing	☐ Self-esteem	☐ Handling everyday tasks	☐ Recreational activities	☐ Relationships
☐ Hygiene	☐ Work/school	☐ Legal Matters	☐ Health	☐ Finances

Have you ever had thoughts, made statements or attempted to hurt yourself? ☐ No ☐ Yes, please describe: ____________

____

Have you ever had thoughts, made statements or attempted to hurt someone else? ☐ No ☐ Yes, please describe: ________

____

Have you recently been physically hurt or threatened by someone else? ☐ No ☐ Yes, please describe: _______________

____

What are your 3 main treatment goals that you would like to accomplish in therapy?

1. ____
2. ____
3. ____

FAMILY AND DEVELOPMENTAL HISTORY

Family and household members:

Name	**Age**	**Gender**	**Relationship**	**Living with you?**

Family Psychiatric History:	**Who?**		**Who?**
Hyperactivity	____________________	Trauma History	______________
Obsessive-Compulsive	____________________	Depression	____________________
Suicide attempts	____________________	Anxiety	____________________
Panic Attacks	____________________	Anger/Abusive	____________________
Schizophrenia	____________________	Eating disorder	____________________
Alcohol/drug abuse	____________________	Other: _______________	____________________

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PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Do you have a Psychiatric Advance Directive (PAD)/Crisis Plan? ☐ Yes ☐ No

Have you been the victim or at risk for domestic violence, emotional, physical or sexual abuse? ☐ No ☐ Yes, please describe: ____

Other trauma or losses: ____
____

SUBSTANCE USE HISTORY

☐ None

Substance Type	**Current Use (last 6 months)** Y	N	Frequency	Amount	**Past Use** Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine								
Heroin/Opioids								
Amphetamines								
Hallucinogenic								
Prescription								
Other:								

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)	**Yes**	**No**
1. Have you felt you ought to **C**ut down on your drinking or drug use?		
2 Have people **A**nnoyed you by criticizing your drinking or drug use?		
3. Have you felt bad of **G**uilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first in the morning to steady your nerves or to get rid of a hangover (**E**ye-opener)?		
4 or > = positive CAGE, further evaluation is indicated. Yes = 1 No = 0.2		

What are your reasons for using? (e.g. addicted, build confidence, escape, social, medicate, etc.) ______________________
____

Do you believe your substance use is a problem? ☐ No ☐ Yes, please describe: ______________________
____

Have you had withdrawal symptoms when trying to stop using any substances? ☐ No ☐ Yes, please describe: _________
____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? ☐ No ☐ Yes, please describe: ____

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MEDICAL INFORMATION

How would you describe your physical health? ☐ Good ☐ Fair ☐ Poor Date of Last physical exam: __________

Allergies: ____

Indicate which of the following medical conditions **currently** affect you.

☐ Asthma ☐ Headaches ☐ Stomach aches ☐ Cancer
☐ Chronic Pain ☐ Surgery ☐ Serious accident ☐ Traumatic Brain Injury
☐ Vision Problems ☐ Seizures ☐ Meningitis ☐ Dizziness/fainting
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Miscarriage / Abortion
☐ Thyroid Disorder ☐ Sleep disorder ☐ Sexually transmitted disease ☐ Other: ___________________

Are you currently being treated for the medical conditions listed above? ☐ No ☐ Yes, please describe. _______________
____

List current medications and over-the-counter: ☐ None

Medication	Dosage	Date first prescribed	Reason	Prescribed by

Primary Physician's Name: ________________________________ Physician Phone: ___________________________
Would you like your therapist to coordinate care with your physician? ☐ Yes ☐ No

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Race: ☐ White ☐ Black or African American ☐ Asian ☐ Other ________________________
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ______________________________

How would you identify your sexual orientation? ☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual
☐ transsexual ☐ asexual ☐ unsure / questioning ☐ other ☐ prefer not to answer

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: ______________________________
____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs to be incorporated into your counseling? ☐ No ☐ Yes, please describe. ______
____

Are you satisfied with your current social life? ☐ No ☐ Yes, please describe. ______________________________________
____

What do you consider to be your strengths? ____
____

What do you like most about yourself? ____
____

What are effective coping strategies that you have learned? ____
____

KARITAS COUNSELING
ADULT CLIENT INFORMATION
OCCUPATION / EDUCATION / MILITARY / LEGAL INFORMATION

Occupational History:
Are you currently: ☐ Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Employer: ________________________________ Position: __________________________
Length of time in this position: _______________ Stress level of this position: ☐ Low ☐ Medium ☐ High

Education:
Are you currently attending school? ☐ Yes ☐ No
☐ High School Graduate? Or ☐ GED? Graduation Year: ____________
☐ Associate's Degree Year: ________ Major area of study: ______________________________________
☐ Undergraduate Degree Year: ________ Major area of study: ______________________________________
☐ Graduate Degree Year: ________ Major area of study: ______________________________________

Military Service:
Have you been/are you currently in the military? (If no, skip this section.) ☐ Yes ☐ No
Branch: ____________________ Date of discharge: ___________ Type of discharge _________________ Rank ________
Were you in combat? ☐ Yes ☐ No

Legal:
Have you ever been convicted of a misdemeanor or felony? ☐ No ☐ Yes, please describe: ____________________
____
Do you have any current or pending legal issues? ☐ No ☐ Yes, please describe: _________________________________
____

For Therapist Use Only:

MSE: Orientation: ☐ Time ☐ Person ☐ Place **General Appearance:** ☐ Neat ☐ Unkempt ☐ Bizarre
Mood: ☐ Relaxed ☐ Anxious ☐ Fearful ☐ Suspicious ☐ Depressed ☐ Irritable ☐ Angry ☐ Euphoric ☐ Guarded
Affect: ☐ Appropriate/Congruent ☐ Inappropriate ☐ Blunted ☐ Flat ☐ Constricted ☐ Expansive
Speech: ☐ Rapid ☐ Slow ☐ Ordinary ☐ Hesitant ☐ verbose ☐ Mute ☐ Loud ☐ Soft ☐ Rambling ☐ Incoherent
Cognition: ☐ Easily distractible ☐ preoccupied ☐ denial ☐ sufficient
Thought Patterns: ☐ Coherent ☐ Confused ☐ Disorganized ☐ Delusional ☐ Tangential ☐ Other: ______________
Insight: ☐ Good ☐ Limited ☐ Poor ☐ None **Judgment:** ☐ Good ☐ Fair ☐ Poor
Risk Assessment:
Suicidal: ☐ Current ☐ Ideation ☐ Plan ☐ Attempt(s) ☐ none disclosed
☐ Past ☐ Ideation ☐ Plan ☐ Attempt(s)
Describe: ____
Homicidal: ☐ Current ☐ Ideation ☐ Plan ☐ Attempt(s) ☐ none disclosed
☐ Past ☐ Ideation ☐ Plan ☐ Attempt(s)
Describe: ____
General Impression of risk to self or others: ____
Diagnostic Impression (include dsm-v code): ____
Recommendation(s): ☐ Individual counseling ☐ Family Counseling ☐ Substance abuse education
☐ Substance abuse counseling ☐ Parenting ☐ Domestic violence education ☐ Other: _____________________
Suggested treatment plan goals: ____
____

____ ____________________________
Clinician Signature and Title Date