Collins Counseling and Associates, P.C.

PATIENT REGISTRATION

(Please Print)

Date _____ Clinician _____

Name _____ Social Security # _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Email Address_____

☐ Home Phone (_____) _____ ☐ Work Phone (_____) _____

☐ Mobile/Alt. Phone (_____)_____ **PLEASE √ BOX FOR WHICH # IS BEST TO REACH YOU**

May we leave a voice message for you? ☐ Yes ☐ No

Would you like to receive a text reminder of your appointments? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partner ☐ Separated

Date of Birth: _____ **Age:** _____

Name of Employer (or School) _____

Emergency Contact name and phone #: _____

RESPONSIBLE PARTY

Responsible Party _____ Relationship to Patient _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security # _____ Place of Employment _____

If other family members are seen in this office, please list: _____

***** AT THIS TIME A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID IS REQUESTED *****
ALTHOUGH WE TAKE A COPY OF YOUR INSURANCE CARD, WE DO REQUIRE THE FOLLOWING INFORMATION TO BE COMPLETED.

Primary Insurance Company:

Name: _____

Policy # _____ Group # _____

Subscriber Name: _____

DOB _____ SSN _____

Employer:_____

Secondary Insurance Company:

Name:_____

Policy #: _____ Group #:_____

Subscriber Name:_____

DOB:_____ SSN:_____

Employer:_____

Collins Counseling & Associates
Adult Client Questionnaire

Patient Name: _____Date: _____
Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: _____

What are your goals for counseling?

_____

_____

_____

_____

Please circle ALL of the following symptoms or thoughts that apply to you <u>AT THIS TIME or during the past six months:</u>

- ☐ Depressed mood
- ☐ Diminished interests or pleasure
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Hopelessness
- ☐ Pleasure in few activities
- ☐ Weight change
- ☐ Agitation
- ☐ Excessive worry
- ☐ I feel like I am losing control
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Tension
- ☐ Feelings of panic
- ☐ Socially withdrawn
- ☐ Use of alcohol
- ☐ Use of other drugs
- ☐ Use of tobacco
- ☐ Anxiety in social settings
- ☐ Makes careless mistakes
- ☐ Does not complete tasks
- ☐ Difficulty organizing
- ☐ Forgetful
- ☐ Confusion
- ☐ Disorientation
- ☐ Compulsive checking / counting
- ☐ Indecisiveness
- ☐ People talk about me
- ☐ Some people want to hurt me
- ☐ I feel emotionally distant from others
- ☐ I hear voices or sounds others do not hear
- ☐ I see things others do not see
- ☐ I smell things others do not smell
- ☐ Racing thoughts
- ☐ I do risky or dangerous things
- ☐ Little interest in sexual activity
- ☐ Sexual problems
- ☐ Gender concerns
- ☐ I don't like my body
- ☐ Binge eating
- ☐ Self induced vomiting
- ☐ Laxative abuse
- ☐ Excessive fasting
- ☐ Intense fear of weight gain
- ☐ Impulsive
- ☐ I think about hurting myself
- ☐ I have tried to hurt myself
- ☐ Sometimes I wish I were dead
- ☐ I think about hurting someone else
- ☐ Exposed to a significant traumatic event
- ☐ Recurrent distressing dreams

Suicide Risk

Have you ever tried to harm yourself in the past? ☐ Yes ☐ No

In the last 6 months, have you had thoughts of ending your life? ☐ Yes ☐ No

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Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medication, over-the-counter medications or supplements and how often you take them/dosage:

_____

_____

_____

Current/Past medical problems, hospitalizations or surgeries:

_____

_____

_____

Have you ever received treatment for any of the following medical conditions?

- ☐ Neurological impairment
- ☐ Seizure disorder
- ☐ Visual loss / impairment
- ☐ Hearing loss / impairment
- ☐ Dementia
- ☐ GI disorder
- ☐ Obesity
- ☐ Significantly underweight
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Heart condition
- ☐ Hypertension
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Tuberculosis / +PPD
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Pregnancy
- ☐ Irregular menstrual periods
- ☐ Musculoskeletal condition
- ☐ HIV / AIDS / Related condition

For women:

Date of last menstrual period: _____Are you currently, or do you think you are pregnant? ☐ Yes ☐ No

Are you planning to get pregnant in the near future? ☐ Yes ☐ No

Family History (Medical/Psychiatric Diagnoses, Substance Abuse or Self-Injury/Suicide):

_____

Past Psychiatric History

Outpatient treatment ☐ Yes ☐ No. If yes, Please describe when, by whom, and nature of treatment.

_____

_____

_____

Psychiatric Hospitalization ☐ Yes ☐ No. If yes, describe for what reason, when and where.

_____

_____

Substance Use:

Do you (or others) t hink you may have a problem with alcohol or drug use? ☐ Ye s ☐ No

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances and when/where were you treated? _____

Days/wk drinking alcohol: _____ Avg. Number drinks/day: _____ Most drinks/day: _____

Do you have current/past problems with the use/abuse of illegal substances? If so, which substances?

_____

Have you abused prescription medication? If so, which medications? _____

How many caffeinated beverages do you drink a day**?** Coffee _____ Sodas _____ Tea _____

Tobacco/Cigarette History: _____

Family Background and Childhood History:

Were you adopted? ☐ Yes ☐ No Where did you grow up?_____

List your siblings and their ages: _____

Did your parents divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____

If your parents divorced, with whom did you live? _____

Educational History:

What is your highest educational level or degree attained? _____

Spiritual life: Do you belong to a particular religion or spiritual group? _____

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Trauma History:

Have you experienced traumatic events in the past? ☐ Yes ☐ No.

Occupational History:

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled Retired

What is/was your occupation? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

How long? _____ Total number of marriages? _____

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? _____

Are you sexually active? ☐ Yes ☐ No

How would you identify your sexual orientation?

☐ heterosexual ☐ homosexual ☐ bisexual ☐ other

Do you have children? ☐ Yes ☐ No. If yes, list ages and gender_____

Legal: Have you ever been arrested? _____ Do you have any pending legal problems?_____

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PHQ-9 & GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things	☐	☐	☐	☐
2	Feeling down, depressed or hopeless	☐	☐	☐	☐
3	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4	Feeling tired or having little energy	☐	☐	☐	☐
5	Poor appetite or over eating	☐	☐	☐	☐
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1	Feeling nervous, anxious or on edge	☐	☐	☐	☐
2	Not being able to stop or control worrying	☐	☐	☐	☐
3	Worrying too much about different things	☐	☐	☐	☐
4	Trouble relaxing	☐	☐	☐	☐
5	Being so restless it is hard to sit still	☐	☐	☐	☐
6	Becoming easily annoyed or irritable	☐	☐	☐	☐
7	Feeling afraid as if something awful might happen	☐	☐	☐	☐