

Admission Form

Client's Name: _____ Today's Date: _____

DOB: _____ If client is a minor, name of guardian: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ May I leave a message on voicemail?: Yes NO

Cell Phone Number: _____ May I leave a message on voicemail?: Yes NO

Email address: _____ May I email you? Yes NO

Marital status (Please circle): Single Married Divorced Separated Widowed Other

Please check the family structure that best describes your home: Biological family _____

Stepfamily _____ Single parent family _____ Couple/No Children _____ Other _____

Employer/School Name: _____

Occupation: _____ Employer /School Phone Number: _____

May I contact you at this number?: Yes No

Emergency contact #1: Name: _____ Phone Number: _____

Have you previously been in counseling? _____ If yes, where? _____

When?: _____ Duration?: _____

Who referred you to our services?: _____

Do you wish to be on my mailing list?: _____

Any Alcohol Use? _____ How often: _____

Recreational. Drug use: _____ Type(s): _____ How often: _____

Positive Steps

Empowering people to take positive steps

Any past suicidal thoughts?: _____ If Yes, when?: _____

Outcome? (Hospitalization? etc): _____

Any current suicidal thoughts? _____ Do you have a plan?: _____

Method?: _____ Additional suicidal Information: _____

Any homicidal ideations?: _____

Any previous mental health diagnosis? If yes, please list:

Any medical conditions? If yes, please list:

Any prescribed medications? If yes, please list:

List any medical or psychiatric conditions of your parents and or siblings:

What are your religious/spiritual beliefs?: _____

How important are they? _____

