Family Solutions Counseling, PLLC

10400 N Vineyard Suite A
Oklahoma City, OK 73120
(405) 242-5305

Date: ____________________

BACKGROUND INFORMATION

Last Name: _________________________ First Name: ________________________ MI: ____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐ F Ethnicity _________

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

Address: _________________________ City: __________________ State: ____ Zip: _______

Home Phone:________________ Work Phone:________________ Cell Phone:______________

E-mail________________________Grade (If Applicable):______School (If Applicable): _________________

Check if we can leave a message on your: ☐ Home phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _________________________ First Name: _________________________ MI: ___

Address: _________________________ City: ____________________ State: ____ Zip: ______

Home Phone: _____________ Work/Other Phone: _____________ Relationship: ____________

HEALTH CARE RESOURCES

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None

Provider: _____________________ Policy ID Number: ____________Policy Group Number______________

Policy Holder (cite name as is appears on the insurance card): ____

Policy Holder Employment:____

Policy Holder Date of Birth __________________________ Additional Info____________________________

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐ Alone ☐ w/Significant Other ☐ in Community Based Shelter
☐ Other: ____________________ Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _________________, First ________________, MI ___ Age __ ☐ Male ☐ Female
Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female
Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

OTHERS LIVING IN HOME (use back if needed)

Name: ________________________________ Relationship to Client: ______________________

Name: ________________________________ Relationship to Client: ______________________

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

City & State _____________________ If minor, with whom __________________________

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

City & State _____________________ If minor, with whom __________________________

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? ____

Please write a couple of sentences concerning the reason for your request of services.

____

____

____

Please check your employment status □ Full-time □Part-Time □Unemployed □Not in Labor Force

If employed, who is your employer?

____

What is the highest level of education you have received?________________________________

In the past 60 days, how many days have you or the minor been absent from school and/or daycare? ____

Have you served in the military? ____ If so what is your current status? _____________________

Are you currently receiving any government assistance? ____ If so, what programs? ___________

Please check all that apply □ Medicaid □ Medicare □ SSI □ SSDI

Are you currently using tobacco products? ___ If so, please describe your use. _______________

How many days have you used tobacco in the past 30 days?______________________________

Are you currently using alcohol? ___ If so, please describe your use. _______________________

Are you currently using other substances? ___ If so, please describe your use. ________________

How many times have you been in jail in the past 30 days?__________ 12 months?___________

Have you ever experienced (check all that apply): □ Physical Abuse, □ Emotional / Verbal Abuse, □ Sexual Abuse / Molestation / Sexual Misconduct, □ Neglect, □ I would rather not answer these

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) _______________________________________

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) __________________________________

Client Name____ CONFIDENTIAL

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

If yes, describe: ____

____

Physician Name: ______________________________ Phone: ______________________

Address: ________________________ City, State, Zip: ____________________________

Are you currently taking medications? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
☐	____________________	_____________	________	________________________
☐	____________________	_____________	________	________________________
☐	____________________	_____________	________	________________________

Please list any allergies:____

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
___________	_______	__________________	______________________________

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
___________	_______	__________________	______________________________
___________	_______	__________________	______________________________
___________	_______	__________________	______________________________

How many self-help meetings have you attended in the past 30 days?_____________________________

Please include any other information you feel is important for therapist to know.

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Client Name____ CONFIDENTIAL