Laurie Adkins Counseling

940-367-4115
LAdkinscounseling@gmail.com

Client Demographics: - Please complete the information **relevant to the client**

Client's name: _____ Date: _____

Address:_____ City, State:_____ Zip:_____

By entering your telephone contact information below, you are giving permission for me to leave messages on your voice mail in regards to your appointments and billing balances.

Home: ( )_____Work: ( )_____

Cell: ( )_____ Email:_____

Client birth date: _____ Age: _____ Gender:_____

How did you hear about us?_____

Client employer or School:_____ _____Grade:_____

Any barriers to learning or accommodations in place at school?_____

_____

Client significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

If parents are divorced or not married, who is custodial parent or legal guardian?_____
Please provide copy of paperwork if applicable

Are you or your child currently seeing a therapist? _____

List all therapists the client has seen, dates seen, and contact information:

_____

List any medications the client is currently taking:

_____

List any inpatient psychiatric or substance abuse treatment client has had, and dates:

_____

History of family mental illness or treatment?_____

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Belief in a higher power?_____

Any significant (current) family stressors?_____

Development: Significant developmental milestones reached as expected? Yes/No

Explain:_____

Problems relating to any of the following: Peers_____ Parents_____

Teachers_____ Siblings_____ Other adults_____

Explain:_____

What kind of problem brings you to counseling?

Please indicate with a C if you are having any of the following problems currently and a P if you've had the problem in the past. Leave blank if you've never experienced problem. Please note if there is a pattern with time of day or trigger:

_____ Sleep difficulties (too much, too little, trouble falling or staying asleep)

_____ Problems in school (behavior or learning) or work

_____ Change in appetite, weight loss, or weight gain

_____ Frequent crying

_____ Panic attacks or anxiety attacks

_____ Thoughts (or attempts) of killing or hurting myself

_____ Avoid doing things or being with people that I used to like

_____ Problems concentrating

_____ Periods of daily sadness lasting more than two weeks

_____ Can't stop remembering upsetting past events

_____ Difficulty controlling anger/temper tantrums/irritable

_____ Guilt or shame

_____ Bed wetting or accidents in clothing

_____ Excessive worry

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_____ Nightmares/flashbacks

_____ Throw up, use laxatives, or exercise excessively to lose weight

_____ Startle easily/hypervigilant

_____ Feel like I am an outsider /isolating myself from others

_____ Sexual behavior problems_____

_____ Frequent arguments with the people I live with

_____ Hear voices inside my head or see things that aren't there

_____ Physically injury myself

Other (please list):_____

_____ _____

Client or Parent of minor child Date