Multicultural Counseling & Research Center

Date: _____

Name:_____

DOB: _____ **Age:** _____

Address: _____

City_____**State**_____ **Zip Code:** _____

How long have you lived at this address? ___ Yr __ Mo
☐ Own ☐ Rent☐ Temporary

Living Situation: **List all persons currently living in household**

Name	Age	Sex	Relationship to client
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Are you satisfied with these living arrangements?
☐ Yes ☐ No ☐ Indifferent

Emergency contact: _____
(name)
_____/_____
(phone number) (relationship)

E-mail Address: _____

Phone #: (day/evening) **(** **)** _____

May we leave a message on your voice mail?
Yes ☐ No ☐

Insurance Carrier:

Policy Number: _____

Address: _____

Gender ☐**Male** ☐**Female**

Country/State of Origin: _____
Year of entry: _____

Highest level of Education _____
Occupation_____How Long?_____

Current Work/Academic Status:
☐ Part-Time ☐ Full-Time ☐ Unemployed ☐ Disabled

How did you find out about our Counseling Services?
☐ Friend ☐ Relative
☐ Brochure ☐ Mental Health professional
☐ Internet ☐ Other: _____
(specify)

Have you had counseling before? ☐ No ☐ Yes
Name of Counselor: _____
Where? _____
When? _____

Have you ever been hospitalized for an emotional or mental health concern? ☐ No ☐ Yes
When: _____

Have you ever been on medication for an emotional or mental health concern? ☐ No ☐ Yes
Medication: _____
Purpose: _____
When: _____

Do you receive any type of case management services? ☐ No ☐ Yes

With whom do you spend most of your free time?
☐ Family ☐ Friends ☐ Alone

How many close friends do you have? ☐

FAMILY INFORMATION

Please describe your current marital status: ☐ Single ☐ Married ☐ Living with partner ☐ Widowed ☐ Divorced ☐ Separated ☐ In process of getting divorced ☐ Other_____

Do you have frequent arguments with your spouse/partner? ☐ Yes ☐ No
If yes, what are some of the most common topics of your arguments?

List any history of mental illness or addiction in immediate family (ex: depression, anxiety, manic-depression, suicide attempts, alcoholism, drugs, etc.):

ALCOHOL/DRUG USE AND TREATMENT HISTORY

Do you use: Cigarettes ____ Alcohol ____ Drugs _____
If yes, what kind? Specify amount and frequency per week:

List drugs used within 48 hours:

Have you used drugs in the past? ☐ Yes ☐ No
If yes, when, how often, and what type?

Have you ever been hospitalized/detoxified for alcohol/drug use? ☐ Yes ☐ No
If yes, please specify how often (include dates):

Do you or others consider your drinking a problem? ☐ Yes ☐ No ☐If so, who? _____

Have you ever seriously considered or attempted suicide? ☐ Yes ☐ No If **YES**, please explain the circumstances.

_____

_____

Do you have any significant medical conditions or significant medical history? ☐ Yes ☐ No If **YES**, please explain.

_____

_____

Describe any events or situations in your childhood that may be affecting your current functioning or situation (e.g. abuse, tornado, death in the family, etc.).

_____

_____

How would you describe yourself?

_____

_____

Trauma History

	Yes	No
Have you been verbally abused?	☐	☐
Have you been physically abused?	☐	☐
Have you been sexually abused?	☐	☐

Other stressors/ traumas or fear?

_____

Please complete the following:
I am a person who

_____

It's hard for me to admit

_____

One of the things I can't forgive

_____

What I wanted from my father and didn't get was

_____

What I wanted from my mother and didn't get was

_____

Section 2: Description of Presenting Problem

In your view, briefly, what is/are your present problem(s) for which you are seeking counseling? _____

_____

Is this a crisis? ☐ Yes ☐ No If **YES**, please explain

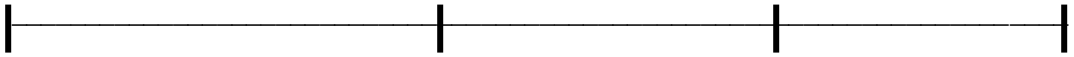
_____

_____

How long has this been a significant problem for you? _____

Why are you seeking counseling now for this problem(s)?_____

How would you estimate the severity of the problem at this time? (Place "X" on the line below)



Mild Moderate Serious Severe

Please describe any incident or problems that may have contributed to this problem (e.g. problem with work/school, relationship ending, past trauma, etc.):

_____

_____

In the past, what had been helpful to you in dealing with this problem? _____

_____

Are you currently experiencing problems at work, school, with family/friends? ☐ Yes ☐ No

How do you handle anger? _____

Have you ever been given a mental health diagnosis in the past from a mental health professional?
☐ Yes ☐ No If YES, as you understand it, what is/was that diagnosis? _____

What would you like to see different after treatment? Please list three goals you would like to reach in counseling:

1. _____

2. _____

3. _____

Areas of Concern		
☐ Academic	☐ Financial Problems	☐Relationship
☐ Adjustment to Life event	☐ Grief/Loss	☐Religious/spiritual issues
☐ Alcohol/Drugs	☐Guilt	☐ Self-Esteem/Self-confidence
☐ Anxiety	☐ Health Concerns	☐ Sexual Concerns
☐ Body Image	☐ Homesickness	☐ Sexual Orientation
☐ Career/Work /School	☐ Identity	☐ Sleep Problems
☐ Decision-Making	☐ Insecurity	☐ Social
☐ Depression	☐ Legal Matters	☐ Social /Family Relations
☐ Discrimination (e.g. racism, sexism, homophobia)	☐ Living Situation Housing Problems	☐ Stress
☐ Eating Related	☐ Past/Current Trauma	☐ Substance Abuse
☐ Family of Origin	☐ Personal Concerns	☐ Suicidal Thoughts
☐ Fears/Phobias/Worries	☐ Personal Goals	☐ Other: _____

Symptoms Related to Concerns		
☐Abuse	☐Fatigue/Loss of Energy	☐Rapid Heart Rate
☐Aggressive Behavior	☐Fears/Phobias	☐Recent Weight Gain
☐ Anger, Irritability, or hostile feelings	☐Feelings of Hopelessness	☐Physical stress (headache, stomach pain, muscle tension)
☐Avoidance	☐Feelings of Worthlessness	☐Recent Weight Loss
☐Can't Fall Asleep	☐Impulsive behaviors	☐Restlessness/ Hyperactivity
☐Confusion	☐Jumpy	☐Self-mutilation
☐Constant Worrying	☐Loneliness, homesickness	☐Shortness of Breath
☐Crying	☐Low Motivation	☐Shyness/being assertive
☐Decreased Need for Sleep	☐Mood swings	☐Sleeping Too Much
☐Depressed Mood	☐Neglect	☐Social Isolation/Withdrawal
☐Difficulty Concentrating	☐Nightmares	☐Stomach Problems
☐Distrust	☐Obsessions/compulsions	☐Sweating
☐Dizzy or Lightheaded	☐Odd Behavior/Thoughts	☐Taking Drugs
☐Drinking Alcohol	☐Outbursts of Temper	☐Trembling or Shaking
☐Easily Distracted	☐Overeating	☐Vomiting
☐ Elevated Mood	☐Pain	☐ Work/School related stress
☐Family Stress	☐Paranoid Thoughts	☐Other: _____

What are your interests/strengths?_____

Is there anything else that you think would be helpful for me, as your therapist, to know? _____

HOW I WANT MY COUNSELING TO GO

Since there are many ways to go about working together in counseling, I would like to know how you want things to unfold for you. Your decisions will inform me of how best to support you and assist you in this endeavor.

1. I want to use my appointment times to: (choose up to 3)

___ Get things off my chest and vent
___ Figure things out
___ Receive emotional support
___ Explore possibilities for my future
___ Determine what changes I want
___ Set goals and steadily work on achieving them
___ Other

2. I want to mainly focus on: (choose up to 5)

___ Gaining understanding about myself
___ Understanding my situation better
___ Developing skills
___ Building on my strengths and abilities
___ Processing past traumatic experiences
___ Recovering and healing
___ What my needs are
___ My job/career
___ The past
___ The present
___ The future
___ Changing my behavior or habits
___ Changing the way I think
___ What is missing from my life
___ My relationships
___ My performance (ex: work, school, various roles or responsibilities)
___ Having a sense of fulfillment
___ Other

3. In general, I would like you, as my counselor, to: (choose up to 3)

___ Support me
___ Challenge me
___ Listen to me
___ Teach me
___ Help me be motivated
___ Advise me
___ Other

4. Is there anything that you don't want to focus and spend time on?

*Naturally, sometimes things change over time. If you change your mind on any of the above, please let me know so that we can adjust for that together.