Chrysalis
Center for Counseling
and Eating Disorder Treatment

3240 Burnt Mill Drive ◇ Suite 1 ◇ Wilmington, NC 28403 ◇ Tel: 910-790-9500 ◇ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential.

Demographic Information:

Name: ______________________________ SSN: _______________ Date: _______________

Mailing Address: ____

____

City: ___________________________ **State:** ___________ **Zip Code:** _____________

Email Address: ____

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

Which phone is the best way to contact you? ____________ Is it okay to leave a message? Yes No

__________	_____	_____	_______________	____________________
Date of Birth	Age	Sex	Ethnic Group	Religious Preference

Relationship Status:

Single _____ Cohabitating _____ Married _____ Separated _____ Divorced_____ Widowed _____

Emergency Contact: ______________________________ Telephone: (_____) ______________

Parent/Guardian Name (if relevant): ____

Address: ______________________________________ Telephone: (_____) ______________

Referral Information:

How did you find out about our services? ____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? ____

What is your job title? ____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing:

Education Information:
Highest Level of Education Completed:
Grade School ___________ High School ______ College ______ Graduate School __

Are you currently a student? Yes No
If yes, where? _________________________ Year ___________ Major _______________

Family/Significant Others:
Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

If anyone in your family has a history of the following, please check all that apply and specify on the chart above: Mental Illness ____ Substance Abuse ____ Eating Disorder ____ Obesity ____ Dieting ____

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities:_____________________
____
____

Allergies/Adverse Reactions to Treatment:____
____

Primary Care Physician Name: ____

Telephone: (______) _______________ Address: ____

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

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Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)

_____Individual Counseling
_____ Group Counseling
_____ Couples/Family Counseling
_____ Nutritional Counseling
_____ Bariatric Evaluation
_____ Assessment

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, and with whom? ____

____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify)________________________
_____ Physical Abuse
_____ Sexual Abuse/Molestation
_____ Sexual Assault
_____ Verbal/Emotional Abuse
_____ Suicidal Thoughts or Feelings
_____ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_____ Self-Confidence/Self-Esteem
_____ Body Image
_____ Anger Management
_____ Peer Relationships
_____ Romantic Relationships
_____ Family Relationships
_____ Divorce/Separation
_____ Sexual Identity Issues
_____ Legal Problems
_____ Racial/Cultural Issues
_____ Other stress (please specify)____
_____ Financial Problems
_____ Unemployment
_____ Learning Disabilities
_____ Loneliness/Social Isolation
_____ Career Planning
_____ Academic Performance
_____ Spirituality
_____ Decision Making
_____ Pregnancy (past, present)

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.
_____ Quite well, no important complaints.
_____ Fairly well, but have ups and downs.
_____ So-so, can keep going with effort.
_____ Quite poorly, can barely manage.
_____ Very poorly, can't manage.

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COUPLES' INTAKE CHECKLIST

Client Name: ______________________________ Date: ______________________

The scale below indicates different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the one that best describes the degree of happiness, all things considered, in your relationship.

Extremely unhappy	Fairly unhappy	A little unhappy	Happy	Very happy	Extremely happy	Perfect

Please check **one** of the following statements that best describes how you feel about the future of your relationship.

___ I want desperately for my relationship to succeed and I would go to almost any lengths to see that it does.
___ I want very much for my relationship to succeed and I will do all that I can to see that it does.
___ I want very much for my relationship to succeed and will do my fair share to see that it does.
___ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to make it succeed.
___ It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
___ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Please indicate below how often the following items occur between you and your partner.

	Never	Less than once a month	Once or twice a month	Once a week	Once a day	More often
Discuss or consider divorce, separation, or terminating the relationship						
Leave after a fight						
Regret that you got together						
Quarrel						
"Get on each other's nerves"						
Think things are going well						
Confide in your partner						
Have a stimulating exchange of ideas						
Kiss each other						
Share outside interests or activities						
Laugh together						
Calmly discuss something						
Work together on a project						

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COUPLES' INTAKE CHECKLIST

Most people have disagreements in their relationships. Please identify which areas you feel are current problems in your relationship and indicate with a checkmark the extent of the problem for those items:

	Minor problem	Occasional problem	Significant, intermittent problem	Significant, ongoing problem
We fight all the time and never get anywhere				
Spillover of other stress(es) in relationship				
Issues with in-laws or other relatives				
Financial issues				
Sex life issues				
Issues with household chores or errands				
Issues with parenting/children				
Violence in the relationship				
Drug or alcohol use/abuse				
Extra-relationship affair/flirting/jealousy				
Emotional distance				
Relationship is becoming passionless or non-romantic				
Not dealing well with another life change (one or both of you)				
We have basic differences in values/goals/lifestyle preferences				
We are not working as a team				
We don't have fun together anymore				
Spiritual issues				
Friend/community issues				
Neither of us is willing to give in on particular issues				
We don't express affection or caring to each other				
We have different ideas about how to demonstrate affection appropriately				

In your own words, what brings you to counseling and what issues would you like to address. Also, please share any other relevant information that you would like us to know.

___

___

___

___

___

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**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): ____________________

Address: ____________________

Telephone: ____________________

Birth Date: ____________________

Social Security Number: ____________________

Relationship to Policy Holder:____________________

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): ____________________

Policy Holder's Address: ____________________

____

Policy Holder's Telephone: ____________________

Policy Holder's Birth Date: ____________________

Policy Holder's Social Security Number: ____________________

Employer's Name: ____________________

Insurance Plan Name: ____________________

Subscriber Number or Member ID Number: ____________________

Group Number: ____________________

* Please see reverse side for secondary insurance information and consenting signature.

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Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

____

Policy Holder's Telephone: ______________________________

Policy Holder's Birth Date: ______________________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number or Member ID Number: ______________________________

Group Number: ______________________________

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

______________________________ ______________________________

Name of Client (printed) Date

____

Signature

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