

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

Clinical Information:

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

- | | |
|--|---|
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Bariatric Evaluation |
| <input type="checkbox"/> Couples/Family Counseling | <input type="checkbox"/> 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?

- | | |
|--|---|
| <input type="checkbox"/> A recent and/or important loss (please specify) _____ | |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Verbal/Emotional Abuse |
| <input type="checkbox"/> Sexual Abuse/Molestation | <input type="checkbox"/> Suicidal Thoughts or Feelings |
| <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Homicidal Thoughts or Feelings |

Are you having current difficulties with any of the following?

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

How well are you getting along psychologically at this time?

- | | |
|---|---|
| <input type="checkbox"/> Very well, the way I want to. | <input type="checkbox"/> So-so, can keep going with effort. |
| <input type="checkbox"/> Quite well, no important complaints. | <input type="checkbox"/> Quite poorly, can barely manage. |
| <input type="checkbox"/> Fairly well, but have ups and downs. | <input type="checkbox"/> Very poorly, can't manage. |

SYMPTOM CHECKLIST

Instructions: The questions below ask about things that might have bothered you or caused problems. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**. If the problem has happened in the past, even if it is resolved, please check “In the past.”

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	In the past	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (office use only)	
I.	Little interest or pleasure in doing things?		0	1	2	3	4		
	Feeling down, depressed, empty or hopeless?		0	1	2	3	4		
II.	Feeling more irritated, grouchy, or angry than usual?		0	1	2	3	4		
	Feeling more tired than usual for no reason?		0	1	2	3	4		
	How long do these feelings usually last?								
	What is the longest they have ever lasted?								
III.	Sleeping less than usual, but still have a lot of energy?		0	1	2	3	4		
	Starting more projects than usual or doing more risky things than usual?		0	1	2	3	4		
	Feeling unusually high, charged up, excited or restless?		0	1	2	3	4		
	Had other people ever said that you were too high, charged up, excitable, or talkative?		0	1	2	3	4		
	How long have these moods usually last?								
	What is the longest they have lasted?								
IV.	Feeling nervous, anxious, frightened, worried, or on edge for days at a time, even when you didn't have anything special to do?		0	1	2	3	4		
	Feeling panic or being frightened?		0	1	2	3	4		
	Avoiding situations that make you anxious?		0	1	2	3	4		
	Have these feelings ever bothered you on and off for six months or more at a time? If so, how long did they last and when did this occur?								
	Feeling very afraid of certain things like heights, animals, needles, the sight of blood, lightning, etc?		0	1	2	3	4		
	What were you afraid of?								
	Feeling so afraid to leave home by yourself that you wouldn't go out?		0	1	2	3	4		
	Feeling afraid to go to supermarkets, go into tunnels, or use elevators?		0	1	2	3	4		
Feeling so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?		0	1	2	3	4			
Did you see a doctor because of this and if so, what did the doctor tell you about these symptoms?									
Having a lot of physical problems that have forced you to see different doctors?		0	1	2	3	4			
V.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?		0	1	2	3	4		
	Feeling that your illnesses are not being taken seriously enough?		0	1	2	3	4		

	Doctors having difficulty finding what caused the problems?		0	1	2	3	4	
	Did you start having any of these problems before you were 30 years old? How old were you?							
VI.	Thoughts of actually hurting yourself?		0	1	2	3	4	
VII.	Hearing things other people couldn't hear, such as voices even when no one was around?		0	1	2	3	4	
	Feeling that someone could hear your thoughts or that you could hear what another person was thinking?		0	1	2	3	4	
VIII.	Problems with sleep that affected your sleep quality over all?		0	1	2	3	4	
IX.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?		0	1	2	3	4	
	Having consistently had difficulty focusing and paying attention?		0	1	2	3	4	
	Feeling impatient, restless, and difficulty sitting still?		0	1	2	3	4	
	Others describing you as impulsive and/or hyper (e.g., do you tend to blurt out comments, interrupt others, say or do things you regret later)?		0	1	2	3	4	
X.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?		0	1	2	3	4	
	Feeling driven to perform certain behaviors or mental acts over and over again?		0	1	2	3	4	
	Doing things in an exact way or order even if it didn't make sense?		0	1	2	3	4	
XI.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?		0	1	2	3	4	
XII.	Not knowing who you really are or what you want out of life?		0	1	2	3	4	
	Not feeling close to other people or enjoying your relationships with them?		0	1	2	3	4	
	Being very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc.?		0	1	2	3	4	
	Having more trouble handling these situations than most people would?		0	1	2	3	4	
	Having flashbacks in which you found yourself reliving some terrible experience over and over?		0	1	2	3	4	
XIII.	Drinking at least 4 drinks of any kind of alcohol in a single day?		0	1	2	3	4	
	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?		0	1	2	3	4	
	Using any of the following medicines ON YOUR OWN (without a doctor's prescription), in large amounts, or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?		0	1	2	3	4	
	Anyone remarking on or expressed concern about your use of alcohol or drugs?		0	1	2	3	4	

	Having drug or alcohol use cause other problems in your life?		0	1	2	3	4	
XIV.	Feeling fat even when other people express concern that you are thin enough or too thin?		0	1	2	3	4	
	Eliminating foods or restricting your overall food intake?		0	1	2	3	4	
	Eating so much you make yourself feel sick?		0	1	2	3	4	
	Eating to comfort, soothe, reward, or punish yourself?		0	1	2	3	4	
	Feeling that your eating was excessive and/or not really normal?		0	1	2	3	4	
	Feeling out of control when eating?		0	1	2	3	4	
	Worrying all the time about food or weight issues?		0	1	2	3	4	
	Feeling depressed, ashamed, or disgusted after eating?		0	1	2	3	4	
	Vomiting, using laxatives or diuretics, or exercising excessively to try to make up for eating too much?		0	1	2	3	4	
	Please fill out the <i>Eating and Body Image Check Sheet</i> form if you have had any of these issues, past or present.							
	Other feelings or symptoms that we have not mentioned? Specify:		0	1	2	3	4	

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain. _____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain. _____

Has your health ever suffered as a result of any of these symptoms? If yes, please explain. _____

Have you ever received medication or treatment for any of these symptoms? If yes, please explain. _____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates. _____

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can. _____



**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.

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