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

Basic Information

Name(s) _____ Age(s) _____
Address _____ City _____State _____ Zip _____
County: _____ Referral Source: _____

Contact Information

When you are contacted, I want to ensure your confidentiality and privacy. Please indicate whether or not a message may be left. Phone: _____ Voicemail/Texts: Yes No
Email: _____ Yes No

Local Emergency Contact:

Name: _____ Relationship: _____
Phone Number: _____

Insurance Company & Member ID: _____
OB Provider Name & Phone #:_____
Pediatric Provider Name & Phone #: _____
Psychiatric Provider Name & Phone #: _____

Occupation/Employer/School:_____
Highest level of education completed: _____

Relationship Status: (please circle)

Single Engaged Married Separated Divorced Widowed Remarried Cohabitating
Spouse: _____ Spouse Occupation: _____

Pregnancy History

Number of Pregnancies? _____ Was this a planned pregnancy/current or most recent? _____
Number of Living Children? _____ Have you ever been given fertility meds? _____
Number of miscarriages? _____ Number of selective terminations? _____ Number of adoption placements? _____Number of adopted children? _____

Last delivery information:

Name of baby: _____ Baby's birth weight? _____

Date of birth: _____ Due date: _____ Baby's gender: _____

Where did you deliver? _____ Was there a NICU stay? _____

How are you feeding your baby? How is it going for you?

_____

_____

When baby sleeps, are you able to sleep? How is sleep going for you?

_____

_____

How is your appetite/diet? Exercise/movement?

_____

_____

Names & ages of other children:

_____

_____

Have you participated in previous counseling or psychological services with a psychiatrist, psychologist, therapist, pastor or lay counselor? N____ y____

Please circle type above. If current, name(s) and contact number(s):

_____

_____

Pertinent Health Information:

List any major health problems for which you currently receive treatment:

_____

_____

List all medications you are now taking:

Name	Dosage	Frequency	For what condition?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Medication	Good/bad effects	Medication	Good/bad effects	Medication	Good/bad effect
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	
Campral		Luvox		Suboxone/ Subutex	
Celexa		Marplan		Symmetrel	
Chloralhydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Emotional/Psychological/Behavioral Health Issues or Needs:

Have you ever been diagnosed with a psychiatric illness *(including but not limited to depression, anxiety, eating disorder, bipolar disorder, substance use, etc.)*? Yes No If yes, what and by whom?_____

_____

Have you ever received treatment and/or been hospitalized for any above diagnosed illness? Yes No If yes, date, level of care (OP, IOP, Residential/inpatient), facility, and length of stay:

_____

_____

Do you currently use: Alcohol or Drugs - Never Rarely Socially Frequently Daily (circle one) Are you in treatment (such as outpatient or MAT) or utilizing support groups (such as AA/NA)? Yes No If yes, please describe:

_____

Current risk factors: (check all that apply)
Suicidal: Yes No Ideation Plan Intent w/o means Intent with means
If yes, explain: _____
Homicidal: Yes No Ideation Plan Intent w/o means Intent with means
If yes, explain: _____
Self-Injury: Yes No If yes, explain: _____
Impulse control: Sufficient Moderate Minimal Inconsistent Explosive

Risk History:
Past Suicide Attempts: Yes No If yes, please clarify age/circumstance:

_____
Homicide: Yes No If yes, explain: _____
Self Injury: Yes No If yes, explain: _____

Family History:
Family of origin (Please Circle): **Mother:** living/deceased **Father:** living/deceased
What words would you describe your relationship with:
Mother:_____Father:_____
Are your parents: Married Living Together Unmarried but in a relationship with each other Divorced Separated Remarried Other: _____
Are you adopted: Yes No If yes, at what age: _____
Did your family have adequate food, shelter, and other basic needs met? Yes No If no, explain:

_____
Did you feel loved growing up? Yes No If no, explain:

_____
How were you punished or disciplined? _____

Describe the values you learned growing up in your family?

_____
Is there a history of substance abuse, addictions, or mental illness in your family?

_____

Social History and Relationships:
Who or what makes up your current support system?

_____
Is it easy for you to make and keep friends? Yes No If no, explain: _____

_____
Are you in a relationship with someone at present? Yes No If yes, describe relationship and your level of satisfaction with the relationship:

_____
Is it easy for you to develop and maintain romantic relationships? Yes No If no, explain:

_____
Describe leisure/recreational activities you engage in and/or enjoy:_____

_____

Spiritual History:
Religious Upbringing: _____ Present Affiliation:_____
Is this an important part of you life? Yes No

Sexual History:

Are you sexually active? Yes No Age at which you became sexually active: _____

Would you describe yourself as: (please circle)

Heterosexual Heterosexual with some same-sex attraction Bisexual Gay/Lesbian
Gay/Lesbian with some opposite sex attraction Asexual Transgender Questioning

Have you ever been bullied, physically or emotionally harmed because of your sexuality?
Yes No If yes, describe: _____

Have you ever been forced or coerced to have sex? Yes No Not sure

_____

Do you need alcohol or other drugs to feel comfortable having sex? Yes No

_____

Do you have any questions or concerns about your sexuality, sexual relationship(s) or sexual health you would like to discuss with your therapist? Yes No

Birth Story: If you are comfortable, please share any relevant information that you feel I need to know about your pregnancy, delivery experience, and postpartum period?

_____
_____
_____
_____
_____
_____

What are your top three strengths?

_____
_____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations?

_____
_____

Client Signature: _____ Date: _____

Thank you for taking the time to complete this information. This is strictly confidential!