



Beacon

COUNSELING CENTER

Beacon Counseling Center
100 Oak St
Wylie Texas 75098

Please answer the following questions to the best of your ability. If you need additional space for answers then please use the back of this form. If there are any questions that you prefer to discuss in person, then please feel free to leave it blank.

SOCIAL HISTORY

CLIENT INFORMATION:

SELF:

Name: _____ Date: _____
Address: _____ City _____
Phone No. _____ (Home) _____ (Cell) _____
Age: _____ Sex: M / F
Email Address: _____
Birth date: _____
Employer: _____ Occupation: _____

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Address: _____ Phone: _____
Employed: Full Time _____ Part Time _____ Student: Full Time _____ Part Time _____
SS or ID#: _____

SPOUSE: or PARENT(S)

Name: _____
Address: _____
Phone No. _____ (Home) _____
(Work) _____ (Cell) Age: _____ Sex: M / F
Email Address: _____
Education Level: _____ Birth date: _____
Employer: _____
Occupation: _____
Address: _____ Phone: _____
Employed: Full Time _____ Part Time _____ Student: Full Time _____ Part Time _____
Insurance Provider: _____ Group #: _____
Primary Person Insured: _____ SS or ID#: _____
Referred to this office by : _____

FAMILY HISTORY:

What kind of relationship do (did) you have with your father? (circle one) Excellent Good Fair Poor Non-existent

What kind of relationship do (did) you have with your mother? (circle one) Excellent Good Fair Poor Non-existent

Did anyone else have a key role in your upbringing? (circle one) Yes / No If yes who and why? _____

How many children are in your family of origin? _____ Where are you in birth order? (circle one) 1st 2nd 3rd 4th 5th 6th Other _____

Any step- brothers or sisters? _____ Any half-brothers? _____

Please use three or four words to describe the following (⊕i.e., kind, anger, etc.)

Your female parent: _____

Your male parent: _____

Your Family of origin: _____

CURRENT LIFE:

Marital Status: (circle one) Single Engaged Married Separated Divorced Widowed

If married, at what age were you married? _____ Your Spouse? _____

If divorced, how many times (circle one) 1 2 3 4 5 6 7 If widowed, at what age? _____

How many years? _____ How many children do you have? _____

How many are living with you now? _____ List Names and ages:

Who else lives with you other than spouse and children? _____

Please use three or four words to describe the following (i.e., loving. Distant, etc)

The main person in your life: _____ Your current family: _____

EMERGENCY CONTACT

Name: _____

Address: _____

Phone No. _____ (Home) _____ (Work)

_____ (Cell) Age: _____

Relationship: _____

MENTAL/EMOTIONAL HEALTH HISTORY

FAMILY HISTORY:

Are there or has there ever been any of the following problems in your family? (check one)

- Substance abuse If so, what? _____
- Suicide Suicide Attempts How many?
- Violence Incest Sexual Abuse
- Depression or anger Anxiety or panic
- Bi-Polar Disorder a/k/a manic depression "Nervous Breakdown"
- Psychiatric Hospitalization

Have you sought counseling before? (circle one) Yes/ NO

With whom? _____

Are you willing to sign a "Release of Information" form so that your counselor may write for social, psychiatric, or medical reports if needed (circle one) Yes/ NO

Have you ever attended a support or therapy group? (circle one) Yes/ NO

Have you experienced any thoughts of harming yourself? (circle one) Yes/ NO If yes, when _____
Describe briefly _____

Did you experience any type of abuse as a child? (Physical, sexual, verbal, psychological) _____
If so, please explain _____

CURRENT ISSUES : (check any)

- Depression or anger Anxiety or panic Work Issues
- Marital Problems Violence or abuse Parenting
- Eating Disorder Adjustment to an event or situation
- Substance abuse If so, what? _____

Please give a brief description about why you are coming to therapy _____

Please give a brief description about how you think the situation developed. _____

Please state what you hope therapy will do for you and your situation. _____

YOUR OBSERVATIONS: (answer briefly)

What was your childhood like? _____

What is your current life like? _____

What is your understanding of your problem? _____

How have you tried to solve it? _____

Are there any other observations that you feel might be important to note in your current life situation? _____

PHYSICAL HISTORY

HEALTH:

Please rate your health: (circle one) Excellent Good Fair Poor

List any medications you take and why: _____

List any current medical problems not included above: _____

Date of last physical exam: _____

Please list your primary care physician with his / her address and phone number: _____

List all important present or past illnesses, injuries, or handicaps: _____

List any family members, including yourself, with physical health problems and medications taken: _____

SPIRITUAL HISTORY

Do you have a belief system (religious, cultural, moral, and spiritual, etc...) which influences your life? If so, please explain _____.

The above information is correct to the best of my knowledge. I understand that a written case record containing personal data, interview notes, test results and necessary psychological reports will be kept on each client. This information is privileged and will be held in strict professional confidence except in cases when the client or others are in personal danger and / or laws of agencies or civil authorities are at issue.

___/___/___

DATE

Signature of Client Guardian