TRIAD COUNSELING CENTERS

Client Information and History (Adult – Confidential)

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Emergency Contact: Name: _____ Phone: _____

Relationship to Contact: _____

Are you seeking counseling due to a legal situation? YES ☐ NO ☐ If yes, are you required to provide documentation? YES ☐ NO ☐

Are you currently employed? YES ☐ NO ☐ If yes, do you enjoy your work? _____

Place of Employment: _____

Length of Employment: _____

Have you ever, or do you currently, serve in any branch of the military? YES ☐ NO ☐

If yes, please list branch and past or current status: _____

Education

High School: _____ Address: _____

College: _____ Degree: _____

Are you currently in school? _____ Full or Part-Time? _____

Other Educational Information: _____

Family (Origin)

Family of Origin History.

Birth Status: **Natural ☐** **Adopted ☐** Where were you born?

Any trauma surrounding your birth?

Did you grow up with both parents in the home?

What is the marital status of your parents? Married ☐ Separated ☐ Divorced ☐ Together; Unmarried ☐ Never Married ☐ Unknown ☐

If married: Are your parents still married? If not together? when did the relationship end?

Are your parents living or deceased?

Mother's Name & Age if living:

If deceased, date of death: Cause of death:

Father's Name & Age if living:

If deceased, date of death: Cause of death:

Do you have any siblings?

If yes, please list their names and ages:

Do you have any siblings that have passed away?

If deceased, date of death: Cause of death:

Quality of Relationships: Please also list other family members not mentioned above that are part of the family of origin: *(step-parents, grandparents, adoptive parents, family members who raised you, etc.)*

Family Member Name:	**Family Member Role:** *(parent, sibling, etc.)*	**Please describe the quality of the relationship:**

(Continued) **Family Member Name:**	**Family Member Role:** *(parent, sibling, etc.)*	**Please describe the quality of the relationship:**

Any current or significant past physical trauma?

Have you had any past physical abuse?

Have you had any past sexual abuse?

Are you currently experiencing abuse of any kind?

Is there any significant mental health history in your family of origin?

How would you describe your family environment? **(Childhood)**

In childhood, what you're your religious affiliations/spiritual or belief systems? Do you still identify as such?

Did you attend church as a family?
What (if any) social and community organizations did your family belong:

Any other significant events in childhood you would like to note?

Family (Present)

Current Family Information:

Are you currently married? YES ☐ NO ☐ Significant Relationship Information:

Have you ever been married? YES ☐ NO ☐

Are you in a long-term or significant relationship? YES ☐ NO ☐

Name of Spouse/Significant Other: Together for? Relationship Status:

Current Relationship Satisfaction: **Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible ☐ Other ☐ Please describe:**

If married, years together before: Any breaks in the relationship – If yes, for how long?

Are you currently wanting to leave your partner? Reason for Leaving:

Do you have any children? Yes ☐ No ☐ Maybe/Someday ☐ Trying to Conceive ☐ Wishing to Conceive ☐ Do Not want Kids ☐

If yes: Names & Ages:

Any significant issues with your children? (Emotional, Behavioral, Physical, etc.)

Quality of Relationships in Present Family: *If present family is family of origin please list quality of relationships with significant people in your life: close friends, romantic relationships, etc. You may also include these if listing present family, just notate the role as non-family and the relationship.*

Family Member Name:	Family Member Role: ***(parent, sibling, etc.)***	Please describe the quality of the relationship:

In your own words, please tell us what brought you in today:

What are your goals for therapy?

How will you feel once these goals have been accomplished? How will you know when your therapy is complete?

Current Living Situation & Environment:

Do you live alone? YES ☐ NO ☐ If no, I live with: _____

Do you own your home? YES ☐ NO ☐ If no, what is your housing situation? _____

Are you satisfied with your current living situation? YES ☐ NO ☐ Please explain: _____

Do you feel safe in your environment? YES ☐ NO ☐

Please explain: _____

Do you belong to any social/religious/community organizations?

If yes, what?

Are there any legal or other pending events you want to disclose?

Would you say you are financially stable? YES ☐ NO ☐

If no, what is the cause for this? *(Transition, unemployment, etc.)*

Medical History

Have you previously been in mental health treatment or therapy?

Inpatient or Hospital: _____ From: _____ To: _____

Outpatient or Therapy: _____ Why did therapy end? _____

Diagnosis: _____ Are you still being treated for this diagnosis in any capacity? _____

Please explain any other information in regards to this treatment:

Have you ever been treated for substance use?

Type of Facility: _____ From: _____ To: _____

Reason for treatment: _____ Do you currently use this substance? _____

Number of alcoholic drinks per day: _____ Illegal Substance Use? _____

Do you use marijuana? _____ Daily Use? _____

Please explain any other information in regards to this treatment: _____

_____

_____

Do you currently feel that you have any type of addiction (including gambling, smoking, caffeine, etc.) _____

History of use: _____

_____

Has anyone in your family ever been treated for mental health or substance use?

Type of Facility: _____ From: _____ To: _____

Reason for treatment: Current Treatment Status:

Current Medical Information:

Do you feel happy with your appearance?	YES	NO	Do you exercise?	YES	NO
Do you feel excessively tired or weak?	YES	NO	Significant weight loss/gain in the last 6 months?	YES	NO
Loss of interest in food?	YES	NO	Have you had a recent decrease in sexual desire?	YES	NO
Are you currently pregnant?	YES	NO	Are you currently breastfeeding?	YES	NO

Please list any significant surgeries or medical conditions: _____

_____

_____

_____

Please list any medications and/or supplements you are currently taking daily: *(please bring list if you need more space)*

Medication/Supplement:	Dosage:	Reason for Use:

Emotional Behavioral Functioning

Check any of the symptoms that you have experienced in the last year:

	Decreases in Energy		**Restlessness**		**Hopelessness**		**Excessive Guilt**
	Panic		**Cruelty/Vindictiveness**		**Loss of Pleasure**		**Depressed Mood**
	Anxious		**Trouble Sleeping**		**Withdrawn**		**Defiant or Aggressive**
	Poor Concentration		**Indecisive**		**Mood Swings**		**Angry**
	Impulsive		**Irritable**		**Helpless**		**Disturbances in Eating Patterns**
	Excessive use of a substance		**Out of Control**		**Worry**		**Rage**
	Sad		**Uncontrollable Crying**		**Frequent Crying**		**Lack of Motivation**
	Homicidal		**Suicidal**		**Performing Ritualistic Behaviors**		**Low Self-Esteem**

Other Symptoms or Emotions you would like to note:

Check the box that applies to the following statements:

I have had thoughts of suicide in the past.

☐ **Yes** ☐ **No**

I have current thoughts of suicide.

☐ **Yes** ☐ **No**

I have made a recent attempt at suicide.

☐ **Yes** ☐ **No**

I have a plan of how I would die if I were to attempt suicide.

☐ **Yes** ☐ **No**

I have had thoughts of homicide in the past.

☐ **Yes** ☐ **No**

I have current thoughts of homicide.

☐ **Yes** ☐ **No**

I have made plans of homicide.

☐ **Yes** ☐ **No**

I have unnatural thoughts that scare me.

☐ **Yes** ☐ **No**

☐ **Please check this box if you feel that you need immediate crisis help in regards to suicidal or homicidal thoughts or ideas.**

If you have checked the box above and feel that you are in a crisis situation and need immediate help, please inform the front desk staff immediately. If you are not in the physical presence of Triad Counseling when completing this paperwork and feel that you are in an immediate crisis situation, please call 911.

Disclaimers and Signatures

I certify that my answers are true and complete to the best of my knowledge.

I understand that any false or misleading information in my information will alter the course of my therapeutic treatment and will not be of benefit to my mental health.

Name (print): _____

Relationship to Client *(if other/minor)* _____

Signature: _____ Date: _____

Participation in Evaluation Survey

My initials marked next to one of the following statements signify whether I wish to provide anonymous feedback at the completion of treatment to Triad regarding my overall level of satisfaction regarding my treatment.

_____ I wish to participate in the Feedback Survey.

_____ I do not wish to participate in the Feedback Survey.

If at any point during your treatment at Triad Counseling Centers you feel that your treatment is not meeting your goals and you would like to discuss the possibility of entering into therapy with another therapist or pursuing another method of treatment but do not wish to speak directly to your therapist, please email the office manager at info@triadcounselingcenters.com and notate that you have concerns about your treatment so that we can address the issue efficiently and effectively without harm to your therapeutic relationship.

Consent to Treatment

I hereby indicate that I am requesting treatment at Triad Counseling Centers, I understand that such treatment may consist of: evaluation, psychotherapy, counseling and/or generally accepted treatments in the field of mental health or substance abuse. I am voluntary authorizing treatment for myself or my dependent at:

Triad Counseling Centers
5980 S. Main St., Ste. 101
Clarkston, MI 48346

_____ Initial

My signature below indicates that I have read, initialed and understand the aforementioned consents to treatment.

_____ _____

Patient/Parent-Guardian Date

Payment on File:

I would like to keep a payment on file for my copays/payments due YES ☐ NO ☐

Credit Card #		
Exp. Date:	CVV:	Date of Authorization:
Signature:		
I understand that by signing this form I am agreeing to pay my regular balances as notated by the Fee Agreement signed upon intake and that unless otherwise notated, I do not need to give permission each time my credit card is processed.		