Pathways Counseling

Adult Personal Information

Name _____ Date _____

Address _____ Apt _____

City _____ State _____ Zip _____

E-mail _____ Okay to contact? ☐ Yes ☐ No

Home Phone _____ Okay to contact? ☐ Yes ☐ No

Cell Phone _____ Okay to contact? ☐ Yes ☐ No

Work Number _____ Okay to contact? ☐ Yes ☐ No

Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Driver's License# _____ State _____

Employer _____ Occupation _____

Number of different jobs in past 3 years: _____ Highest Schooling Completed: _____

Mental Health Coursework: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

If married, partnered, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner: _____ Date of Birth _____/_____/_____

Have Children? ☐ Yes ☐ No If yes, how many? _____

Name of Children/Other in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: _____/_____/_____

What medications are you taking? _____

_____

Current health issues: _____

Past, Chronic, or Significant Health Issues/Surgeries: _____

_____

In Case of Emergency, I authorize Pathways Counseling to contact _____

Relationship _____ Phone Number _____ Alternate Number _____

How did you hear about us? Please circle: Friend/Family Pathway's Website Psychology Today

Insurance/EAP Referral _____ Other _____

PATHWAYS COUNSELING ASSESSMENT and HISTORY INFORMATION

This information will help you & your therapist begin to clarify your therapy goals.

Name _____ Date _____

☐ Yes ☐ No Have you ever been treated by a psychiatrist?
☐ Yes ☐ No Have you ever been hospitalized for mental or chemical dependency treatment?
☐ Yes ☐ No Have you ever been to counseling before? If yes, when? _____
☐ Yes ☐ No Have you seen another therapist in the **past 24 months**?
If yes, whom did you see? _____
☐ Yes ☐ No Have you ever attempted suicide?
If yes, when? _____
Briefly describe your reasons for seeking counseling services: _____

_____

_____

What have you tried so far to handle this situation? _____

_____

_____

Please place a number that best corresponds to issues listed below that are currently issues. For issues were in the past, please mark "P" for past, with a number to indicate how long ago it was an issue. For example, if you had an issue with prescription drug use 10 years ago, mark "P-10" next to "Drug Use."

Rarely			Sometimes			Often			Always
0-1	2	3	4	5	6	7	8	9	10

_____ Abuse—physical
_____ Abuse—sexual
_____ Abuse—emotional
_____ Abuse—neglect
_____ Aggression, violence
_____ Alcohol Use
_____ Anger, Hostility, irritable
_____ Anxiety, Nervousness
_____ Appetite/Weight Changes
_____ Attention, Distraction
_____ Career concerns, goals, choices
_____ Co-dependence
_____ Confusion
_____ Combat/Combat Exposure
_____ Cruelty to animals
_____ Crying, Sadness
_____ Custody of Children
Other _____

_____ Decision-making, Indecision
_____ Delusions (false ideas)
_____ Depression
_____ Divorce, Separation
_____ Drug Use _____
_____ Eating Problems
_____ Financial
_____ Gambling
_____ Grieving
_____ Goals
_____ Guilt
_____ Headaches
_____ Impulsiveness
_____ Judgment
_____ Loss of Control
_____ Marital/Partner
_____ Memory Problems
Other _____

_____ Menstrual, PMS, Menopause
_____ Mood Swings
_____ Obsessions/Compulsions
_____ Panic/Anxiety Attacks
_____ Parenting
_____ PTSD
_____ Sexual Assault
_____ Self-Esteem
_____ Sexual Issues
_____ Sleep Problems
_____ Stress
_____ Suicidal Thoughts
_____ Tobacco Use
_____ Temper/Low Tolerance
_____ Thought Disorganization
_____ Work Problems
_____ Worry

Pathways Counseling

In the past 36 months has there been a death of a family member or someone close to you? ☐Yes ☐No
If yes, who? _____ When? _____ Relationship? _____

Prior to the 36 month, has there been a death of someone that was close to you? ☐ Yes ☐ No
If yes, who? _____ When? _____ Relationship? _____

Please rate below on a scale of 1 through 10, 1 = not at all and 10 = very much so:

_____ I was very close and had a good relationship with my father.
_____ I was very close and had a good relationship with my mother.
_____ I was very close and had a good relationship with my siblings.
_____ I have several good friends.
_____ I have a tendency of agreeing with other people to avoid confrontations.
_____ I like myself.
_____ I have a healthy interest in sex.
_____ I sometimes am confused with my identity.
_____ I put the needs and wishes of others first before myself even if I'm not comfortable with it.
_____ Others make me mad, disappointed, or sad easily.

Any Current Legal Issues? _____
Any Past Legal Issues? _____
Have you ever filed a complaint against a professional? Yes ☐ No ☐ If yes, please explain: _____
_____

Spiritual/Religious identity growing up: _____ Now: _____
Describe your spiritual and religious practice today: _____
_____
_____

Alcohol: I drink ____ servings of alcohol per ___day, ____week, ____month.
____do not drink alcohol _____in sobriety since __/___/____
Tobacco use: _____
Drug use (including marijuana)
In the past month: _____
Past year: _____
Lifetime: _____

Mother's Occupation _____ Her age _____ Age at Death _____

Cause of death _____

Father's Occupation _____ His age _____ Age at Death _____

Cause of death _____

How would you rate your parent's marriage/relationship? Very happy☐ Happy☐ Ave☐ Unhappy☐

If divorced, what was your age when this occurred? _____

Number of Brothers _____ Number of Sisters _____ You are the _____ child.

Number of previous marriages/partners _____ First names of previous mates, years together, and children from that relationship:

_____

_____

_____

_____

Fears or concerns of counseling: _____

_____

My biggest strength is _____

_____

My biggest weakness is _____

_____

Goal or expectation of counseling: _____

_____

_____