Rochester Area Counseling Services

Welcome to Rochester Area Counseling Services!

Please complete this form and answer the questions below. The information you provide will help us to better meet your counseling needs. The information you provide in this document is protected as confidential information.

Date of Service: _____

Client Information and History

Name: _____
(Last) (First) (Middle Initial)

Parent/Guardian name (if the client is under 18 years old):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____Male _____ Female

Marital Status: _____Never married _____ Domestic partnership _____ Married

_____Separated _____ Divorced _____ Widowed

Spouse/Partner's name: _____

Home Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? ____Yes _____No

Cell/Other Phone: _____ May we leave a message? ____Yes _____No

Email: _____ May we email you? _____Yes ____No

Who referred you to us? _____

_____

Medical/Health Insurance Information (Please note that we are not paneled with some insurance companies. We request this information in case we are. If you have not met your deductible, you will be charged the insurance contracted rate.)
If you do not provide it, you will be charged the self-pay rate of $100.00.

Name of Insurance Company: _____

Contract/Policy/Group No: _____

Name of Primary Policy Holder: _____

Birthdate of Primary Policy Holder: _____

Policy Holder's Employer: _____

Psychosocial Information:

Children (First names and ages; quality of your relationship with children; any other important information):

_____

_____

Parents (Ages; married/divorced/widowed; quality of parents' relationship and of your relationship with parents; any other important information):

_____

_____

Siblings (Gender; ages; quality of your relationship with brothers/sisters; any other important information):

_____

_____

Spouse/Partner (How long have you been married? Quality of relationship; If separated or divorced, how long since the separation/divorce):

_____

Describe your profession/work and your level of satisfaction with your job/career:

_____

_____

Post-High School Education:_____

_____

Describe your hobbies (What you enjoy doing outside of work):_____

_____

Describe how you reduce/relieve your stress: _____

_____

_____

Describe your current level of satisfaction with your spiritual/religious views/beliefs: _____

_____

Medication History

Are you currently taking prescription medication? _____Yes _____No

If yes, list medication(s) and what you take for:

_____

_____

List prescribed medications taken in the past, dates you started/stopped taking them, and reason you stopped:

_____

_____

General and Mental Health Information

How would you rate your current physical health?

_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

What specific health problems are you experiencing now and/or in the past?

_____

_____

How would you rate your current sleeping habits?

_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

List any specific sleep problems now or in the past (e.g. difficulty falling asleep; difficulty staying asleep; early morning awakenings):

_____

_____

List any difficulties with your appetite or eating patterns now or in the past (e.g. Calorie restricting; binging/purging):

_____

_____

Are you currently experiencing sadness, grief or depression? _____Yes _____No
If yes, for how long and describe how bad it gets: _____

_____

Are you currently feeling anxiety, panic attacks or phobias? _____Yes _____No
If yes, for how long and describe how bad it gets:
_____

_____

Are you currently experiencing chronic pain? _____Yes _____No
If yes, describe the pain and how you are managing it? _____

_____

Have you ever hurt yourself on purpose (self-injury such as cutting)? _____Yes _____No

If yes, when did this start and for how long? _____

Have you ever attempted suicide or did something that made others think you wanted to kill yourself?

_____Yes _____No If yes, please explain: _____
_____

List any prior history of mental health and/or substance abuse treatment (e.g. outpatient counseling; inpatient/residential treatment; psychiatric services, etc.), including dates of service:

_____

_____

Substance Use History

Do you drink alcohol more than twice a week? _____Yes _____No
Do you use any illegal substances? _____Yes _____No

If you answered yes to either of these questions, please provide the following information:

Substance	First used at age...	Last used on this date...	Describe frequency of use in past year...	Average amount used each time...	Method of use (smoke, snort, etc.)	The most used in a single day...
Alcohol (Beer, wine)						
Alcohol (Liquor)						
Nicotine (Cigs, e-cigs, Hookah, etc.)						
Marijuana						
Cocaine						
Heroin						
Hallucinogens (Acid, LSD, Ecstasy, etc.)						
Inhalants (Dust-Off, etc.)						

Substance	First used at age...	Last used on this date...	Describe frequency of use in past year...	Average amount used each time...	Method of use (smoke, snort, etc.)	The most used in a single day...
Synthetic drugs (K2, Spice, etc.)						
Prescriptions (Vicodin, Xanax, etc.)						

Family History

Identify your family history for any of the following, indicating the family member's relationship to you in the space provided (e.g. mother, uncle, sister, etc.):

	Please Circle	Family Member
Alcohol/Other drug abuse	Yes / No	
Aggressive behavior	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Eating disorders	Yes / No	
Obsessive compulsive behavior	Yes / No	
Schizophrenia	Yes / No	
Self-injury	Yes / No	
Suicide (Attempt or completion)	Yes / No	

And finally, please share anything else you think might be important in order for us to better help you:

_____

_____

_____

_____

_____

_____

Thank you for choosing Rochester Area Counseling Services!