Travers Counseling & Professional Services

100 N. 6th Street Ste. 402 Waco, Texas 76701

IDENTIFICATION

Name: _____ Age:_____ Sex: _____ Date of Birth: _____

Parent of Guardian (if under 18): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred way to be contacted: Home Phone Cell Email

Any restrictions or special request pertaining to out of office communication: _____

EMERGENCY

Person to call in an emergency and relationship to you: _____

Phone: _____ Address: _____

REFERRAL

How did you hear about Travers Counseling & Professional Services? _____

MARITAL STATUS

Single Engaged Separated Married

EMPLOYMENT

Place of Employment: _____ Gross Family Income: _____

School (if student): _____ Grade/Year/Level: _____

Education/Degrees obtained: _____ Partners: _____

Partner's Place of Employment: _____

Have you served in the military: Yes/No If so, what branch: _____

FAMILY OF ORIGIN

Parents Living/Deceased: _____ Father _____ Mother

Parent's Divorced/Married/Remarried? Date(s): _____

Family Tree - Begin with your parents (1), you and your children (2), your siblings then their children (3):

Name & Age

1. _____
2. _____
3. _____

RELIGIOUS AND RACIEL/ETHNIC IDENTIFICATION

Church Membership: _____ Minister: _____

Religious Preference(s): _____

Involvement: None/Some/Irregular/Regular/Active

How important are spiritual concerns in your life? _____

Ethnicity/National Origin: _____ Race: _____

Other ways you identify yourself or consider important about you: _____

MEDICAL

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relevant medical conditions (history or current):

_____

_____

Medications: _____

Allergies: _____

Learning or other related disability: _____

Have you ever had a head injury: _____ Date: _____

Do you use Alcohol? Yes/No If so, how much per day _____ per week _____ per month _____

Do you use any illegal drugs? Yes/No Type: _____ When: _____ How Often: _____

Any family members with drug or alcohol problem, past or present? _____

COUNSELING

Any counseling/psychotherapy in the past? Yes/No If so, with whom/when: _____

_____

Reason for seeking counseling today: _____

_____

_____

Tell me about your support systems: _____

Who do you feel closest to in your life: _____

Please mark all of the items below that apply:

- I have no problems or concerns
- Abuse – physical, sexual, emotional, neglect
- Aggression, Anger, Hostility, Arguing, Irritability
- Alcohol or Substance Use
- Anxiety, Excessive Worry, Panic, Nervousness, Obsessions, Compulsions
- Career Concerns, Goals or Choices
- Childhood Issues
- Codependence
- Decision Making, Indecision, Mixed Feelings, Procrastination
- Depression, Low Mood, Sadness, Crying, Appetite Change, Low Energy
- Divorce or Separation, Relationship Conflicts
- Financial or Money Troubles, Debt
- Friendship Conflicts
- Grieving, Mourning, Death, Loss
- Health, Illness, Medical Concerns

- Identity Questions, Meaning of Life, Purpose, Quality of Life
- Interpersonal Conflicts
- Impulsive, Irresponsible, Pessimism
- Parenting
- Perfectionism
- School Problems
- Self-Esteem, Self-Neglect, Poor Self-Care
- Sexual Issues
- Spiritual or Religious, Moral, Ethical
- Stress Management, Relaxation, Tension
- Work Problems

Any other concerns or issues: _____

_____

_____

Please look back over the concerns you have checked off and chose the one that you would like the most help with:

_____

_____ _____

Client/Patient **Date**

_____ _____

Counselor **Date**