Reset Form Print Form

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Patient Information and Social History

(ADULT)

Date: Date

Last Name: Patient Last Name First Name: Client Name Middle Name: Patient Middle Name

Address: Patient Home Address

Home Phone: (Primary Contact) Cell Phone: (Patient Cell Phone)

Primary Contact: (Email Address) Work Phone: (Patient Work Phone)

Email: Email Address

SSN: Occupation Birth Date: Age Age: Spouse Age Gender Gender

Occupation: Time on Job Employer: Spouse Employer

Length of Time at Current Job: Time at Job Employer Address: Employer Address

Current Marital Status (check one): ☐ Single (never married) ☐ Widowed ☐ Separated
☐ Divorced ☐ Unmarried/ Cohabitating Couple ☐ Married (how many years ____)

Spouse: Spouse Age: Spouse Age Phone: (Patient Home Phone)

Spouse's Address: Patient Home Address

Spouse's Occupation: Spouse Occupation Employer: Spouse Employer

Emergency Contact: Emergency Contact Relationship: Phone Number

Emergency Contact Phone Number(s): Phone Number

Referral Source: Name

List of all people living in your home:

Name	Current Age/Date of Birth	Relationship
Name	Age or DOB	People in Home Relationship
Name	Age or DOB	People in Home Relationship
Name	Age or DOB	People in Home Relationship
Name	Age or DOB	People in Home Relationship
Name	Age or DOB	People in Home Relationship

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Please check if any of the following problems pertain to you:

Nervousness Depression Fears Shyness Sexual Problems

___Suicidal Thoughts ___ Separation ___Divorce ___Finances ___Drug Use ___Alcohol Use
___Self-Control ___Nightmares ___Sleep ___Children ___Behavioral disorders ___Relaxation
___Anger ___Infertility ___Unhappiness ___Legal Matters ___Ambition ___Work ___Stress
___Headaches ___Fatigue ___Making Decisions Memory Energy ___Insomnia ___Career
Choices Health Problems ___Loneliness ___Education Inferiority Feelings ___Intrusive
Thoughts Parenting Temper Marriage Children Social Issues Eating Disorder
___Appetite ___Impulsivity ___Victim

Health History

Current Primary Care Physician: _____Name_____

Phone: (_____Name_____) Date of Last Visit: _____Name_____

Address: _____Name_____

Please Complete Consent Form for Primary Care Physician

Current Health Problems: _____Current Health Problems_____
_____Current Health Problems_____

Please List all Current Medications:

Medication	Dosage	OTC Y/N
Dosage	Dosage	
Dosage	Dosage	
Dosage	Dosage	
Dosage	Dosage	

Do you have any allergies? **YES/NO** If Yes, describe_____Allergies Description_____

In the past 2 weeks were your sleep patterns (check one): ___Typical or ___Unusual

(Check all that apply): ___Nightmares ___ Insomnia ___Early morning waking

___Difficulty falling asleep ___ Restless

In the past 2 weeks were your daily eating habits (check one): ___Typical or ___Unusual

(Check all that apply): ____1-2 meals ___2-3 meals ___snacks

Do you have any current eating disorders? **YES/NO** Have you had eating disorders in the past? **YES/NO**

If yes, explain: _____Eating Disorders_____

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Are you presently experiencing emotions and/or mood that affect your day-to-day functioning?

	Never	Seldom	Often (5+ times per year)
Anxiety			
Frustration			
Manic States			
Suicidal Thoughts			
Anger			
Mood Swings			

Counseling History

Previous Psychiatric or Psychological Services: **YES/NO**

Reasons for Care: Reasons for Car

Treatment outcome: Date of Services Dates of Services: Date of Services

Current Treatment Provider: Current Treatment Phone Phone: (Current Treatment Phone)

Address: Reason for Care

Reasons for Care: Reason for Care

List any Court ordered evaluations: Support Groups

List any support groups you attend: Support Groups

Is there a family history of (Check all that apply): ___Alcoholism ___Drug Abuse ___Mental Illness ___

Medical conditions that influence emotional states: Medical Conditions

Has anyone in your family been treated for a psychiatric disorder? **YES/NO**

If yes, please explain: Please Explain

Drug and Alcohol History

Have you ever used alcohol to change or alter your behavior or mood? **YES/NO**

If yes, explain: Please Explain

Have you ever used drugs to change or alter your behavior or mood? **YES/NO**

If yes, explain: Please Explain

Has anyone ever suggested you quit or cut back on your drug/alcohol use? **YES/NO**

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Complete the following for family members who have a history of drug/alcohol abuse:

Family Member	Substance Used	Current Use (Y/N)	Treatment Received
Family Member	Treatment Received		Treatment Received
Family Member	Treatment Received		Treatment Received
Family Member	Treatment Received		Treatment Received
Family Member	Treatment Received		Treatment Received

Family and Social History

Father (please answer all questions as it was during your childhood):

Occupation: Education Highest Level of Education Education

Emotional Health: ___Good ___Fair ___ Poor

Physical Health: ___Good ___Fair ___ Poor

Describe your father/child relationship: Father/Child Relationship

Mother (Please answer all questions as it was during your childhood):

Occupation: Mother's Education Highest Level of Education Mother's Education

Emotional Health: ___Good ___Fair ___Poor

Physical Health: ___Good ___Fair ___ Poor

Describe your mother/child relationship: Mother/Child Relationship

Who did you live during your childhood: Growing Up Where did you grow up: Growing Up

List brothers and sisters (including you) in birth order and give their current ages:

Name	Age	Past Relationship	Current Relationship
Past Relationship	Position	Past Relationship	Current Relationship
Past Relationship	Age	Past Relationship	Current Relationship
Past Relationship	Age	Past Relationship	Current Relationship
Past Relationship	Age	Past Relationship	Current Relationship
Past Relationship	Age	Past Relationship	Current Relationship

Describe your childhood, ages 3-11 (check one): ___ Happy ___ Unhappy ___Mixed

Explain: Explain

Describe your adolescence, ages 12-18 (check one):___Happy ___Unhappy ___Mixed

Explain: Explain

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Were you abused: **YES/NO**

___Physically ___Emotionally ___Verbally ___Sexually (*check all that apply)*

Describe: Describe _____

Educational History

Highest level of education achieved: ? _____ Currently Enrolled ? ___ Major Major _____

Time spent on academics per week: ? ____ Expected Graduation Date: ? _____

Did you or do you have difficulty in school? **YES/NO**

If yes, explain: Please Explain _____

Describe any specialized skills, training, certificates, or licenses: Please Describe _____

Vocational Status

Describe your employment history for the past five (5) years beginning with your current position:

Employer	Position	Time in Job	Reason for Leaving
Employer	Position	Time in Job	Reason for Leaving
Employer	Position	Time in Job	Reason for Leaving
Employer	Position	Time in Job	Reason for Leaving
Employer	Position	Time in Job	Reason for Leaving
Employer	Position	Time in Job	Reason for Leaving

Describe any physical/emotional problems that prevent or interfere with employment:

Please Describe _____

Job Performance

Has your employer/supervisor expressed any concerns about your work performance to you? (**YES/NO**)

In the past: (**YES/NO**) Currently (**YES/NO**)

If yes, please check all that apply:

Missing too much work Assigned tasks not completed Irresponsibility
Poor/bad attitude Difficulty getting along with others Tardiness
Attitude/behavior change ___Difficulty getting along with supervisors
Increased errors Other: Other _____

BALDWIN COUNSELING

1492 South Independence Blvd. Suite 104 Virginia Beach, VA 23462
Office: (757) 340-0275 Fax: (757) 340-0276

Military

Have you ever served in the military services: **(YES/NO)** If yes, when? From To_____ to To_____

Branch: Rank_____ Rank at discharge: Rank_____

Did you ever serve in combat: **(YES/NO)** If yes, please describe: Please Describe_____

Legal

Do you have any pending legal action: **(YES/NO)**

If yes, explain:

Pending Criminal Charge Please Describe_____

Name of Court: Court Date_____Court Date: Court Date_____

Pending Domestic: Identify Issue_____ Identify Issue: Identify Issue_____

Name of Court: Court Date_____ Court date: Court Date_____

First name and age of any minors involved:

Name	Age	Relationship
Age	Age	Minor Relationship
Age	Age	Minor Relationship
Age	Age	Minor Relationship

Are you currently on probation or parole: **(YES/NO)**

If yes, explain: Legal Action Probation Please Explain_____

Leisure, Recreational, Interests and Hobbies

Would you consider your life as (yes or no for each area):

Work oriented: **YES/NO** Family oriented: **YES/NO** Self-oriented: **YES/NO**

People oriented: **YES/NO** Leisure oriented: **YES/NO** Recreation oriented: **YES/NO**

Faith Oriented: **YES/NO** Activities you enjoy doing by yourself: Personal Activities_____