Case No. _______

Today's Date: ___________________________

Your Name: ____

Address ____

City: ___________________________________ State ____ Zip ______________

Cell Phone: ______________________ Home Phone: ___________________ Age:______

Email:____ (please write clearly)

Drivers License #:____________________________________State:_____

Occupation ____________________________ Employer: ________________________________

What is your highest level of education completed?_______________________________________

Whom may I thank for referring you to Delray Holistic Therapy?____________________________

Have you been to counseling or therapy before? If so, was it helpful? What did you like or not like?

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Are you having problems with alcohol or other substances?	Yes	No
Have you recently thought about committing suicide?	Yes	No
Have you ever attempted to commit suicide?	Yes	No
Have you ever had psychiatric hospitalization?	Yes	No
Are you now or have you ever been under the care of a psychiatrist?	Yes	No
Have you ever been diagnosed with a psychological "disorder?"	Yes	No

If Yes, what was the diagnosis?: ____________________________________

Do you have any current health problems (injuries, chronic problems, eating, sleeping, etc.)?

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Do you have a lot of stomach aches and/or headaches? If yes, then how often and when?

____

Do you exercise often? YES NO If yes, what do you do and how often?

____

Case No. _______

Do you have any important spiritual beliefs or religious practices that you believe are directly relevant to your counseling? If so, please provide a brief name for them:

____

Please list ALL drugs (prescription, over-the-counter, and recreational, including alcohol & tobacco) that you consume regularly. **Remember that your answers are strictly confidential.**

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Is there any other relevant information you would like to add?

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Your signature below indicates that you have answered the questions above truthfully and fully.

___________________________________	______________	____________________
Signature of client	Date	Printed name
___________________________________	______________	____________________
Sig. of parent, guardian or legal representative	Date	Printed name of minor child