Name: _____ Age: _____ Date of birth:____/____/_____

Address: _____ City:_____Zip: _____

E-mail: _____

Phone:_____ May I leave a message? __Yes __ No

MARRIAGE *(if applicable)*

How long have you been married?
How long did you know your spouse before marriage?

CHILDREN *(if applicable)*

Name:		Age:	Name:		Age:
Name:		Age:	Name:		Age:

Occupation: _____Does your work satisfy you? _ Yes _ No

Religion:_____ Church affiliation:_____

How important are spiritual matters to you? __ Very important __ Somewhat important __ Not important
How were you referred to Corban Counseling? I like to thank those who refer to me personally. Please indicate if this is the case.
I have your permission to contact and thank this person: __Yes __ No
Emergency phone number & contact person if you are coming alone:

INSURANCE REIMBURSEMENT INFORMATION

I accept some insurance companies for payment, however, many of my clients have "out of network benefits" and are able to file for reimbursement for my services. Do you intend to file for reimbursement from your insurance company? __Yes __ No

Name of company: _____

PRESENTING PROBLEM

Describe the reason you are seeking therapy at this time:
How troubling is this to you? __ Mildly upsetting _Moderately upsetting __ Extremely upsetting

What do you consider to be the top two stressors in your life? (l) (2)

SELF ASSESSMENT

Check each of the following that might describe you:

Scattered		Passive		Demanding		Confident		Optimistic	
Defeated		Controlling		Undesirable		Decisive		Inadequate	
Argumentative		Angry		Distant		Withdrawn		Lost	

Check each of the following that describes your mood over the past month:

Angry		Afraid		Bored		Tense		Sad		Guilty	
Annoyed		Anxious		Restless		Confused		Hopeless		Ashamed	
Hurt		Unhappy		Lonely		Frustrated		Depressed		Remorse	

Check any of the following items that you have bad trouble with in the last month:

Sleeping		Appetite change		Racing thoughts		Dizziness	
Impulsiveness		Poor judgment		Aggressive behavior		Rapid heart beat	
Guilt		Loss of sex drive		Frequent crying		Chest pains	
Enjoying life		Very low energy		Headaches		Heavy drinking or drug use	
Concentration		Very high-energy		Shortness of breath		Suicidal thoughts	

Rate your current overall satisfaction with life: Very dissatisfied Very satisfied

1 2 3 4 5 6 7 8 9 10

What would you hope to gain from your time in therapy?
Have you been in therapy before? __ Yes __ No. If "yes," briefly describe your experience:
Have you been hospitalized for psychological treatment? _ Yes _ No
If yes please explain:
Does any member of your family suffer from an emotional or mental disorder? __Yes __ No
If yes, please explain:
Please list any medications and dosages you may be taking for emotional distress

Signature authorizing treatment: _____ Date: ____/____/_____

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