PathLight
COUNSELING

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential.

Client Full Name: _____
(Last) (First) (Middle)

Preferred Name: _____

Name of parent/guardian (if under 18 years):_____

Birth Date:_____/_____/_____ Age:_____ Gender: ◯ Male ◉ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and their ages: _____

Address: _____

_____ _____ _____
(City) (State) (Zip)

Home Phone:_____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone:_____ May we leave a message? ☐ Yes ☐ No

E-mail:_____ May we email you? ☐ Yes ☐ No

Emergency Contact:_____ Phone:_____

How were you referred to us: _____

Is there any additional information PathLight Counseling should know about you?

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

Have you previously received any type of mental health services (therapy, psychiatric services, etc.)? ☐Yes ☐No

If yes, previous therapist/practitioner(s) and dates: _____

Are you currently taking any prescription medication? ☐Yes ☐No
Please list: _____

_____

Have you ever been prescribed psychiatric medication? ☐Yes ☐No
If yes, Please list and provide dates: _____

_____

1. How would you rate your current physical health?
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits?
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐Yes ☐No
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or do you have any phobias? ☐Yes ☐No
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ☐Yes ☐No
If yes, please describe: _____

8. Do you drink alcohol more than once a week? ☐Yes ☐No

9. How often do you engage recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

10. Are you currently in a romantic relationship? ☐Yes ☐No If yes, for how long? _____
On a scale of 1-10 (1=unhealthy/unsatisfying; 10=healthy/satisfying) how would you rate your relationship? Why?

_____

11. What significant life changes or stressful events have you experienced recently: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. Check all that apply. If checked, please indicate the family member(s) relationship to you in the space provided (father, grandmother, uncle, etc.).

	Check all that apply	Family Member
Alcohol/Substance Abuse		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive Compulsive Behavior		
Schizophrenia		
Suicide Attempts		

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐Yes ☐No If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your work or work environment?

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐Yes ☐No
   If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish through your time in therapy?

_____

_____

_____

_____

I,_____(*client or legal guardian*) authorize PathLight Counseling, LLC or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly PathLight Counseling, LLC in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian. **Your signature below also indicates that you have read the Consent for Treatment and HIPPA agreement and agree to the terms.**

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

_____ _____

Signature of Patient or Parent(s)/Guardian(s) Date

_____ _____

Print - Name of Patient or Parent(s)/Guardian(s) Relationship(s) to Patient