Avenues Counseling
Personal
Groups
Training

1612 S. Big Bend Blvd. St. Louis, MO 63117
(314) 529-1391

Personal Information Form

Today's Date: _____ Referred by: _____

Client's Name: _____Date of Birth: _____ Minor? Yes/No
(If applicable, add partner/parent information below)

Home Phone #: _____ Cell Phone #: _____(Please initial next to any phone number(s) where it's OK to leave a message for you.)

Address: _____May we send mail (e.g., a bill or other necessary information) to this address? Please initial: Yes _____No _____

E-mail address: _____ (Please complete the consent to e-mail form if we may correspond with you via e-mail. Form is attached)

Would you like to receive information about upcoming events, groups, or seminars from us? Please Initial: By e-mail _____ By Postal Mail _____ Please don't send me any information ____

Employer: _____ Position: _____ How Long Employed? _____

Do you attend church? Yes/No Church Name _____ Member? Yes/No

Marital Status: Single / Married / Divorced / Separated / Widowed

Partner/Parent Information

Name: _____ Date of Birth: _____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____(Please initial next to any phone number(s) where it's OK to leave a message for you.)

Address (if different than above): _____

E-mail address: _____ (Please complete the consent to e-mail form if we may correspond with you via e-mail. Form is attached)

Employer: _____Position: _____ How Long Employed? _____

Do you attend church? Yes/No Church Name _____ Are you a member? Yes/No

Marital Status: Single / Married / Divorced / Separated / Widowed

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Information About Children

Name	Age	Sex	Living at home?	Years Education	Step Child

Medical and Family History

Have you received counseling or psychiatric treatment in the past? Yes/No If so, please tell me a bit about it:

_____
_____

Please describe any family history of medical and / or psychological problems:

_____
_____

Are you currently taking any medications? Yes/No If yes, please list them below:

Medications	Reason For Medication	Dosage	Frequency

Please describe any current or past addiction(s) (i.e., drug, alcoholic, sexual, etc.):

_____
_____

Please describe any current or past violence or abuse in the home:

_____
_____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that bring you to counseling (your relationship with your parents, their relationship with each other, significant losses and / or events):

_____
_____

Current History

What is happening in your life that has caused you to seek out counseling?

_____
_____
_____

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Please circle any symptom you have had in the past **six months**:

Change in appetite	Problems concentrating
Difficulty sleeping	Low Motivation
Sleeping too much	Isolating from others
Fatigue/low energy	Frequent anger
Low self-esteem	Depressed mood/sadness
Tearful/cry spells	Anxiety/Fear
Hopelessness	Panic

NO SYMPTOMS/STRESS **EXTREME SYMPTOMS/STRESS**

Please place an "X" on the line above to indicate level of problem.

Past History

Have you ever experienced: (Place a check mark by conditions that apply to you)

___ Anxiety ___ Eating Disorder ___ Depression ___ Anger ___ Abandonment

___ Addiction (drugs, alcohol, sex, gambling, pornography, etc.) ___ Adoption Issues

___ Post Traumatic Stress Disorder ___ HIV Positive ___ Post Partum Depression

___ Other _____ ___ Other _____

Social History

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use drugs (illegal/any drug)? _____ If so, how often and which drug? _____

Do you use any tobacco products? _____ Do you smoke? _____If so, packs per day? _____

Do you use vitamin supplements? _____ If so, please list:_____

Do you consume caffeine? _____ If so, how much per day? _____

Do you exercise? _____ If yes, what is the frequency/type? _____

What percentage of time during the day do you spend: Under normal stress: ____% Under considerable stress: ____% Rested/relaxed: ____%

Consent for Treatment

Client Name: _____ Date of Birth: _____

I give permission to **LIANNE JOHNSON, LPC (License # 2003031565)** to provide counseling to me.

As a client of Avenues Counseling it is your right to have the content of your therapy sessions held in confidence with these exceptions in which we are mandated to report: (1) if you sign a release form for us to divulge any or all information, (2) if you intend suicide, or if you intend to do serious physical harm to yourself, (3) if you intend homicide, (4) if a child, elderly person, or disabled person is being abused or has been abused, or (5) in the case of exploitation by a mental health professional.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

Professional Consultation: In following ethical and professional standards, our therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations. **Please Note:** Counselors that are pursuing licensure in the state of Missouri are required to consult regularly with their supervisor.

I have read and agree to the above policies, procedures and statements.

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____

Signature of Counselor Date