Ashlee Howard, M.S., Licensed Professional Counselor, NCC

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Client Information

\*All information is treated as confidential and may be released only with your consent.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List below all other members living in your household:

Name Relationship Age

What is happening in your life that resulted in this appointment?

What would you like to see accomplished in therapy?

Chief complaint (please check all that apply):

\_\_ Depression

\_\_ Low energy

\_\_ Low self-esteem

\_\_Poor concentration

\_\_Hopelessness

\_\_Guilt

\_\_Sleep disturbance (more/less)

\_\_Appetite disturbance (more/less)

\_\_Thoughts of hurting self

\_\_Thoughts of hurting someone

\_\_Isolation/social withdrawal

\_\_Sadness/loss

\_\_Stress

\_\_Anxiety/panic

\_\_Heart pounding

\_\_Chest pain

\_\_Trembling/shaking

\_\_Sweating

\_\_Chills/hot flashes

\_\_Tingling/numbness

\_\_Fear of dying

\_\_Fear of going crazy

\_\_Nausea

\_\_Feeling that you are not real

\_\_Anger/frustration

\_\_Lose track of time

\_\_Unpleasant thoughts

\_\_Easily agitated

\_\_Defies rules

\_\_Blames others

\_\_Argues

\_\_Excessive use of drugs/alcohol

\_\_Excessive use of prescription meds

\_\_Blackouts

\_\_Physical abuse issues

\_\_Sexual abuse issues

\_\_Spousal abuse issues

\_\_ Feeling of “unreality”

\_\_Obsessions/compulsive behaviors

\_\_Thoughts racing

\_\_ Can’t hold onto an idea

\_\_ Excessive behaviors (spending, eating, etc.)

\_\_ Delusions

\_\_Not thinking clearly/confusion

\_\_Phobias

Previous outpatient therapy? Yes \_\_\_\_\_\_ No \_\_\_\_\_

Previous diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous medications?

Previous hospitalizations for psychiatric issues? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_