

One10 Men's Counseling

at Family Care Counseling Center

3959 South Nova Rd, Suite 14

Port Orange, FL 32127

(386) 290-1097

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New Client Information Form

CLIENT INFORMATION

Client's Name _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Mailing Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____

Sex: Female _____ Male _____ Date of Birth _____ Age _____

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Please list children and their ages (if applicable):

Client's Employer _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Phone _____

Driver's License # _____

How or from whom did you hear of One10 Men's Counseling?

☐ Physician

☐ Church/Pastor

☐ Friend

☐ Web Search

☐ Other

In Case of Emergency, contact _____ Phone _____

Physician _____ Phone _____

PARENT/SPOUSE INFORMATION

Spouse/Parent _____ Phone _____

Employer _____ Phone _____

Occupation _____ Social Security # _____

RELEASE OF INFORMATION

I authorize One10 Men's Counseling to obtain/release/exchange information with my Primary Care Physician or other healthcare practitioners for the purpose of service coordination and continuity of care.

Physician's/other practitioner's name _____

Address _____

Phone _____ Fax _____

Check here if you do not authorize this release of information _____

COMMUNICATION BETWEEN YOU AND ONE10 MEN'S COUNSELING

Occasionally it will be necessary for our office to contact you regarding appointments or other matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing to let us leave messages and information. We will always try to be discreet in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your preferred contact phone number? (circle one)

Home _____

Cell _____

Work _____

If you need to make, change, or cancel an appointment, or have questions about your client records or account, please call One10 Men's Counseling at (386) 290-1097.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

PATIENT HEALTH QUESTIONNAIRE

All information is kept confidential in adherence with current HIPAA regulations.

Name: _____

Date: _____

People commonly encounter problems in the following categories. Please indicate how you are affected by each by circling the number that most accurately reflects your feeling.

	Not a Problem 0	Slight Problem 1	Moderate Problem 2	Serious Problem 3	Severe Problem 4
Mood and energy					
1. Feeling sad, depressed, or unhappy	0	1	2	3	4
2. Feeling discouraged or hopeless	0	1	2	3	4
3. Feeling bad about yourself	0	1	2	3	4
4. Little interest or pleasure in things you usually enjoy	0	1	2	3	4
5. Feeling guilty, worthless, or helpless	0	1	2	3	4
6. Crying spells	0	1	2	3	4
7. Restless, irritable, or agitated	0	1	2	3	4
8. Feeling tired or having little energy	0	1	2	3	4
9. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	4
10. Poor appetite or overeating	0	1	2	3	4
11. Trouble making decisions	0	1	2	3	4
12. Difficulty with concentration	0	1	2	3	4
13. Less interest in sex	0	1	2	3	4
14. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3	4
Worry, fear, and panic					
15. Anxious/nervous/worried	0	1	2	3	4
16. Stressed/overwhelmed	0	1	2	3	4
17. Intense fear, panic/discomfort	0	1	2	3	4
18. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizziness, fear of losing control, etc.)	0	1	2	3	4

	Not a Problem 0	Slight Problem 1	Moderate Problem 2	Serious Problem 3	Severe Problem 4
19. Anxiety about being in certain situations (such as in a crowd, traveling, standing in line, etc.)	0	1	2	3	4
20. Anxiety or fear related to being in social situations or having to perform (such as public speaking, test taking, etc.)	0	1	2	3	4
21. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc.)	0	1	2	3	4
22. Worrying about health problems	0	1	2	3	4
Unwanted thoughts and repeated acts					
23. Having unwanted thoughts over and over again	0	1	2	3	4
24. Repeating specific acts over and over (such as hand washing, checking, etc.) or mental acts (such as counting, repeating words)	0	1	2	3	4
Mood swings, impulses, and anger					
25. Euphoria (feeling high)	0	1	2	3	4
26. Sudden changes in mood for no apparent reason	0	1	2	3	4
27. Decreased need for sleep	0	1	2	3	4
28. More talkative than usual	0	1	2	3	4
29. Racing thoughts	0	1	2	3	4
30. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.)	0	1	2	3	4
31. Excessive irritability or agitation	0	1	2	3	4
32. Angry outbursts	0	1	2	3	4
33. Property destruction	0	1	2	3	4
Attention and focus					
34. Making careless mistakes at school, work, or other activities	0	1	2	3	4
35. Difficulty sustaining attention during tasks	0	1	2	3	4
36. Difficulty following through or finishing things	0	1	2	3	4
37. Difficulty in organizing tasks or activities	0	1	2	3	4
38. Easily distracted	0	1	2	3	4

	Not a Problem 0	Slight Problem 1	Moderate Problem 2	Serious Problem 3	Severe Problem 4
39. Losing things or being forgetful	0	1	2	3	4
40. Hyperactivity (can't sit still)	0	1	2	3	4
41. Poor impulse control	0	1	2	3	4

Memory and unusual experiences

42. Hearing things	0	1	2	3	4
43. Seeing things	0	1	2	3	4
44. Experiencing confusion	0	1	2	3	4
45. Memory lapses/forgetting	0	1	2	3	4
46. Feeling of unreality or being outside of self	0	1	2	3	4
47. "Missing time"	0	1	2	3	4
48. Suspiciousness (questioning other people's motives)	0	1	2	3	4

I have been experiencing these problems for:

☐ < 1 month ☐ 1-6 months ☐ 7-12 months ☐ > 1 year

Check the following that have caused concern or difficulties during the last 6 months:

- | | |
|---|---|
| ☐ Taking care of personal grooming needs | ☐ Preparing meals for family/self |
| ☐ Getting along with spouse/parents/children | ☐ Taking care of children/others |
| ☐ Meeting financial obligations | ☐ Enjoying hobbies |
| ☐ Meeting home responsibilities | ☐ Getting along with co-workers/others |
| ☐ Enjoyment of work | ☐ Meeting work responsibilities |

Current life stressors

- ☐ Relationship issues (arguments, separation, divorce)
- ☐ Health issues (illness or injury)
- ☐ Financial issues (owe money, loss of job, unemployment)
- ☐ Abuse (physical, mental, emotional, sexual)
- ☐ Legal difficulties (lawsuit, traffic, criminal charges)
- ☐ Substance abuse (alcohol/drugs/food)

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

_____ Not at all _____ Somewhat _____ Very _____ Extremely

Briefly describe why you are seeking help at this time:

Please check below if you have had any of the following medical conditions:

- | | | |
|--|--|---|
| ☐ Arthritis | ☐ Diabetes | ☐ PMS |
| ☐ Stomach ulcers | ☐ Head injury | ☐ Asthma |
| ☐ Hyperthyroidism | ☐ Seizures | ☐ Other respiratory problems |
| ☐ Hypothyroidism | ☐ Heart attack | ☐ Cancer |
| ☐ Kidney problems | ☐ Angina | ☐ Menstrual problems |
| ☐ Colitis/Crohn's | ☐ High blood pressure | ☐ Pregnancy (____ times) |
| ☐ Chronic pain | ☐ Urinary retention | ☐ Miscarriage (____ times) |
| ☐ Lupus | ☐ Migraines | ☐ Hysterectomy |
| ☐ Tuberculosis | ☐ Chronic headaches | ☐ Surgery: _____ |
| ☐ Other: _____ | | |

Please list all current medications:

Medication	Strength	Frequency	Date started	Prescribed by

Please list all previous psychotropic medications you have ever taken:

Medication	Strength	Frequency	Date started	Prescribed by

Medication Allergies: No _____ Yes _____ (Describe: _____)

Please list all previous counseling/psychiatric treatment, including any psychiatric hospitalizations:

Dates	Reason	Counselor/Doctor

Yes _____ No _____ Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?

Yes _____ No _____ Has any family member ever had any history of depression, anxiety, other mental problems, or suicide? If so, who and what?

Yes _____ No _____ Never _____	1. Do you have thoughts about suicide now?
Yes _____ No _____ Never _____	2. Have you ever thought about suicide?
Yes _____ No _____ Never _____	3. Have you ever attempted suicide?
Yes _____ No _____ Never _____	4. Do you have access to guns/weapons?
Yes _____ No _____ Never _____	1. Are you thinking about hurting someone now?
Yes _____ No _____ Never _____	2. Have you ever thought about hurting someone else?
Yes _____ No _____ Never _____	3. Have you ever hurt someone else?

Please answer the following questions:

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Never

If never, please skip to the next section.

If yes, how many alcoholic drinks do you have in the average

Day _____ Week _____ Month _____ Year _____

If yes to the above, please answer the following:

Yes _____ No _____	Have you ever sought help for alcohol or drug use?
Yes _____ No _____	In the past year, have you ever drunk alcohol or used drugs more than you meant to?
Yes _____ No _____	Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?
Yes _____ No _____	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
Yes _____ No _____	Has anyone ever objected to your drinking or drug use?
Yes _____ No _____	Have you ever found yourself preoccupied with wanting to use alcohol/drugs?
Yes _____ No _____	Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
Yes _____ No _____	Has your drinking or drug use ever caused legal problems (DUIs, violence)?

Check if you have taken any of the following drugs:

Yes _____ (which ones) No _____

If no, please skip to the next section.

☐ Marijuana/Pot	☐ Cocaine/Crack	☐ Inhalants
☐ Amphetamines/Speed	☐ Barbiturates/Sedatives/Downers	☐ Designer drugs, Ecstasy
☐ Heroin/opiates	☐ Intravenous drug use	☐ Tranquilizers (Xanax, Valium)
☐ PCP/Angel Dust	☐ Pain medicine	☐ LSD/hallucinogens
☐ Have you ever taken prescribed medication inappropriately? Yes _____ No _____		

Sleep difficulties (check all that apply):

- | | | |
|--|---|-------------------------------------|
| ☐ None | ☐ Wets bed | ☐ Nightmares |
| ☐ Falling asleep | ☐ Walks in sleep | ☐ Bad dreams |
| ☐ Falling back to sleep | ☐ Snores | |
| ☐ Tired upon waking | ☐ Stops breathing during sleep | |
| ☐ Early morning awakening | ☐ Falls asleep when emotional | |

Usually, the time that I...

Go to bed: _____ a.m. _____ p.m.

Wake up: _____ a.m. _____ p.m.

Smoking:

☐ None

Packs per day: ☐ 1 ☐ 2 ☐ 3 ☐ Other

Age began: _____

Caffeine (cups per day):

☐ Coffee: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

☐ Tea: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

☐ Soda/Other: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

Are you sensitive to caffeine? Yes _____ No _____

Please answer the following questions:

Yes _____ No _____ Is there any history of violence, verbal abuse, or sexual abuse in your family?

Yes _____ No _____ Have you ever been physically abused?

Yes _____ No _____ Have you ever been sexually abused?

Yes _____ No _____ Have you ever experienced or witnessed a traumatic event (accidents, crime, major illness)?

I VERIFY THAT ALL INFORMATION ABOVE IS TRUE AND ACCURATE.

_____ (Signature) _____ (Date)