FOUR ELEMENTS
Integrative Counseling, LLC

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Name: ____ **Date:** __/____/_____

☐**Home Phone:** _______________ ☐**Cell:** ________________☐ **Work:** ____________________

Please check preferred contact number. Can a message be left at this number? Y N

Address: ____ **Zip:** ______________

Email: _______________________________ **Would you like to be added to email list?** ☐**Y** ☐**N**

Demographics: Age: _____ ☐**M** ☐**F** **Ethnicity:** ______________________________________

DOB ___/___/___ **Place of birth:** ____

Referred by: ____

Description of problem or reason for making this appointment:

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Current Stressors:

Relationship Issues: ____

____

Work/Career Issues: ____

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Financial Issues: ____

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Legal Issues: ____

____

Other:

____

____

Background:

Occupation: ___________________________ Highest level of Education: _______________

☐Single ☐Married, How long? _____ ☐Divorced, when__________☐ Widowed, when_____

Spouse/Partner: __________________ Age _______ Occupation: _____________________

Describe Relationship: ____

Children: ______________ Age: ____ Parent: _____________ Residence: _______________

Children: ______________ Age: ____ Parent: _____________ Residence: _______________

Children: ______________ Age: ____ Parent: _____________ Residence: _______________

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Family of Origin:

Birth Order:___ of ____ Parents Divorced ☐Y ☐N When: __________________________

Quality of Parents' relationship: ____

Father: Age ___ Deceased ☐N ☐ Y, Age at death: ________Cause of death: _____________

Describe Father: ____

Mother: Age:___ Deceased ☐N ☐ Y, Age at death: ________ Cause of death: ____________

Describe Mother: ____

Quality of relationship:

Siblings: ____________ Age: ___ Deceased ☐N ☐Y, When:_______ Good Fair Poor

Siblings: ____________ Age: ___ Deceased ☐N ☐Y, When:_______ Good Fair Poor

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Siblings: ____________ Age: ___ Deceased ☐N ☐Y, When:_______ Good Fair Poor

Describe Childhood: ____

____

Early childhood neglect: ☐N ☐Y, Explain: ____

____

Abuse (verbal, emotional, physical, sexual): ☐N ☐Y, Explain: _______________________

____

Any other childhood or adult trauma: ☐N ☐ Y, Explain: ______________________________

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Military Service: ☐N ☐ Y, Branch: ____

Were you involved in combat or in war zone?____________________________________

Past Psychiatric History:

Prior Psychiatrists/Psychologists:

Name	Dates seen	Phone #	Can we contact?
______________________	_______________	__________________	Y N
______________________	_______________	__________________	Y N
______________________	_______________	__________________	Y N
______________________	_______________	__________________	Y N

Prior Counseling: None Yes, Detail below:
Where: When: Reason:

____

____

____

Prior Hospitalizations:
Where: When: Reason:

____

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____

Substance Use History:

Substance	No Use	Past Use-Last used when?	Current Use—please note amount used per day or week
Alcohol			
Marijuana			
Cocaine/Crack			
Heroin			
Pain Meds			
Stimulants			
Tranquilizers/Benzos			
Sleep Medication			
Hallucinogens			
Tobacco			
Caffeine			
Other			

Past Medical History:

Please list the providers you are currently seeing or have seen in past six months

Name Phone Last visit Can we contact?

____

____

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____

Surgical History: Please list surgeries you have had or are planning and approximate dates.

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____

Family History: Please include parents, siblings, children and grandparents (please note M or F for mother or father's side.)

Symptom	Who
Anxiety - (include phobias, panic)	
Attention Deficit	
Bipolar	
Depression	
Eating Disorder	
Learning/Speech Disorder	
Obsessive-Compulsive	
Schizophrenia	
Suicide-completed	
Alcohol Abuse	
Drug Abuse	
Other	

Current Medications:

Past Psychiatric Medications and Supplements:

Medications Vitamins Supplements	Dosage and # per day	Duration	Reason Discontinued	Side effects

Members of your current household (including pets):

Name	Age	Relationship	Quality of Relationship:		
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor
______	______	______	Good	Fair	Poor

Social Support:

Emotional: ______________________________ **Mental:** ______________________________

Physical: ______________________________ **Spiritual:** ______________________________

Religion/Spirituality:

Religious Background: ____

Current Religious/Spiritual Practices: ____

Sleep:

Average # hours per night: ______ Do you have consistent bedtime? ☐N ☐Y, Bedtime:_____

Do you have difficulties falling asleep, staying asleep or waking up? Explain.

____

Quality of Sleep: ☐ well rested ☐ tired upon awakening ☐ nighttime awakenings

Is your sleep disturbed at same time each night? ☐ N ☐ Y, if so at what time: _________

Time of day when feel most energy and least symptoms: ______________________

Time of day when feel least energy and most symptoms: _______________________

Relaxation/Stress Reduction:

Exercise: ☐None Type_____________ __________________Frequency_________________

Means of relaxation: ____

Hobbies/Interests: ____

Environment:

Do you feel safe in your home? ☐Y ☐N, Explain: ___________________________________

Do you work in or frequent environments with exposure to toxic fumes, chemicals, metal?

☐N ☐Y, Explain: ____

Is there anything else you would like me to know about you?

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