Christina Spears-Bartunek, MS, LMHC,CHC

Client Information

Name _____ Age_____ Birthdate_____

Address _____ Marital Status_____

City _____ Zip_____ Phone _____

Employer_____ Email_____

Primary Care Physician _____ Phone _____

Responsible Party (if same as client, please skip to next section)

Name _____ Birthdate _____ Address _____

Phone _____

Insurance Information

Primary Insurance _____ Group#_____ Subscriber#_____

Emergency Contact

Name_____ Address_____ Phone _____

Relationship to patient _____

Please list any past or present psychiatric treatment, counseling, hospitalizations or CD treatment

Dates of Service	Provider Name	Type of Treatment

Please list any medications that you are currently taking

Medication/Dosage	**Date started**	**Reason for medication**

Past/Present Substance Use

Substance form	Frequency of use	Quantity of use
Tobacco		
Alcohol		
Marijuana		
Sleeping pills		
Cocaine		
Opiods		
Amphetamines		

Please indicate if you are experiencing any of the problems listed.

	Absent	Mild	Moderate	Severe
Anxiety				
Repetitive Behavior				
Decreased Sex Drive				
Difficulty Focusing				
Easy Crying				
Agitation				
Hallucinations				
Impulsive Decision Making				
Irritability				
Low Energy				
Mind Racing				
Non-Suicidal Self-Harm				
Panic				
Reduced Enjoyment				
Depression				
Social Withdrawal				
Thoughts of Hurting Others				
Trouble Making Decisions				
Vomiting or Laxatives for Weight Loss				
Loss of appetite or increased appetite				
Lack of sleep or Excessive sleep				

Trauma History

Have you ever been physically abused? Yes No

Have you ever been sexually abused? Yes No

Have you experienced any other accidents or instances that you would consider traumatic? Yes No

What brings you to counseling now?

_____
_____
_____
_____

In the past month...
1. Have you wished you were dead or wished you could to go sleep and not wake up?

If yes to #1
2. Have you been thinking about how you might do this?

3. Have you had these thoughts and had some intention of acting on them?

4. Have you started to work out or worked out details of how to kill yourself? Do you intend to carry out this plan?

5. Have you ever done anything or started to do anything to end your life in the past?