Rebecca N Martin LMHC NCC
Counseling Services

Please print all information in the space provided. DATE:____________

NAME:____DOB:_____________

HOME ADDRESS:____

HOME PHONE: ____________________ CELL PHONE:_________________

WORK PHONE:____________________ EMAIL ADDRESS:__________________

EMPLOYER:_______________________ OCCUPATION:____________________

MARITAL STATUS:__________________

INDICATE IF YOU EXPERIENCED ANY OF THE FOLLOWING BEHAVIORS, OR HAVE ANY OF THE FOLLOWING CONCERNS:

Nervousness/Anxiety	Anger	Shame
Poor concentration	Poor self control	Loneliness
Mood shifts	Volatile relationships	Shyness
Nightmares	Panic attacks	Emptiness/Boredom
Fears	Low Energy/Fatigue	Inferiority Feelings
Depressed Mood	Poor self-esteem	Suicidal thoughts
Aggression	Homicidal thoughts	Sadness
Loss	Poor physical health	Marriage and Family Issues
Financial Issues	Use of Pornography	Sexual Issues
Career Issues	Infidelity	Legal Problems

Use of Alcohol: Daily how many drinks?
OR Weekly how many drinks
OR Occasionally, OR Never

Use of Substances: Daily, Weekly, Occasionally, Never

Any Family members with diagnosed or suspected mental illness?_______________

Please List ____

Previous contact with mental health professionals? Yes___________ No________

If yes, please state year, provider of service and reason for treatment.____________

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Please list any psychotropic medications:_____________________________________

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Prescribed by: Primary Care Doctor ___________

Psychiatrist ___________________

Emergency Contact: _________________________________

Phone number: _____________________________________

Goal in seeking
counselling____
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