Breakthrough
Mental Health Counseling

Welcome! Please complete the following information sheet to provide me with your contact information, medical and personal history, and help me understand your current concerns. Leave blank any items that do not apply. Thank you! Also, please provide your insurance card (if applicable), a photo ID, and a credit card for your records.

Basic Information

Legal Name: _____

Date of birth: _____/_____/_____ Preferred name (if any): _____

Last 4 of SSN: _____

Home Address: _____

_____

HIPAA Agreement: Did you receive a copy of the Privacy Policy describing how personal health information is used? □ Yes □ No

PCP Release: Would you like me to be able to communicate with your medical doctor regarding concerns we discuss in counseling? □ Yes □ No

If yes, please provide their name(s) and phone number(s) _____

Signature _____

Referral Information (Optional) Who referred you to Alexis Cleckner, LPC?

_____

Is it ok to thank this person/office for their referral? □ Yes □ No

Contact Information

Mobile Phone: _____ Ok to leave messages at this number? □ Yes □ No

Home Phone: _____ Ok to leave messages at this number? □ Yes □ No

Work Phone: _____ Ok to leave messages at this number? □ Yes □ No

E-mail Address: _____ OK to contact? □ Yes □ No

Would you like to get appointment reminders? □ No reminders □ E-mail reminders

Emergency Contact Name: _____

Relation to you: _____

Phone: _____ □ Mobile □ Home □ Work

E-mail Address: _____

Home Address: □ Same as client, or: _____

_____

Contact Release: Would you like me to be able to communicate with your emergency contact regarding your attendance in counseling? □ Yes □ No

If yes, please provide the date in which you would like to terminate this release (enter date in MM/DD/YYYY format please)_____

Signature _____

Would you like me to be able to communicate with your emergency contact regarding concerns we discuss in counseling? □ Yes □ No

If yes, please provide the date in which you would like to terminate this release (enter date in MM/DD/YYYY format please)_____

Signature _____

Identity Information

Relationship Status: □ Single □ Partnered □ Married □ Separated □ Divorced

Gender: _____

Racial and/or ethnic identity: _____

Sexual identity/orientation: _____

Religious/spiritual identity: _____

Have you ever experienced any stress or discrimination based on any aspect of your identity? If yes, please explain:

_____

_____

Education and Work Information

Highest level of education completed:

□ Grade _____

□ Associate's degree □ GED □ Bachelor's degree □ High school □ Grad/Prof. degree □some college

Current job status:

□ Employed ---> Job title: _____ Employer _____

□ Part-time Student ---> Work hrs./week: _____

□ Full-time Student

□ Unemployed

Job/work stress: □ Always □ Often □ Sometimes □ Rarely □ Never

Financial stress: □ Always □ Often □ Sometimes □ Rarely □ Never

Have you served in the military? □ Yes □ No

If "Yes" to military service, what branch? _____

When? _____

Deployed? □ Yes □ No

Where? _____

Legal History

Have you ever been arrested? □ Yes □ No

Convicted of a crime? □ Yes □ No

Are you involved in any litigation currently? □ Yes □ No

Medical Conditions and History

Have you had any of the following medical concerns?

□ Thyroid problems □ Concussion □ Low iron (anemia) □ Seizure

□ Head injury or TBI □ Migraines □ Chronic pain

□ Other (specify): _____

Do you have a documented or diagnosed disability? □ Yes □ No

If "Yes," please indicate which type of disability (check all that apply):

□ Deaf or Hard of Hearing □ ADD/ADHD or Learning Disability □ Visual Impairment

□ Mental Health Disorder □ Mobility Impairment □ Physical/health-related Disorders □ Chronic Pain

□ Other (specify):

_____

Please list all current medications (including hormones, if applicable):

_____

_____

Name of your Primary Care doctor: _____

Practicing at what agency/hospital: _____

Phone: _____

Do you see a psychiatrist? □ Yes □ No

Name of psychiatrist: _____

Practicing at what agency/hospital: _____

Phone: _____

Mental Health History

Have you had previous counseling? □ Yes □ No

When? _____

For what? _____

Was it helpful? _____

Are you aware of any family history of mental health concerns (e.g., anxiety, depression, substance use, suicides)? □ Yes □ No

If "Yes," please list the relation to you and the type of concern:

_____

_____

_____

Presenting Concerns Which of the following have been a concern for you lately (check all that apply):

□ Unhappines	□ Social anxiety	□ Work or school
□ Irritability or anger	□ Panic attacks	□ Spirituality
□ Mood swings	□ Eating/appetite	□ Grief or loss
□ Worrying	□ Body image or weight	□ Identity
□ Anxiety or stress	□ Sleep	□ Sexuality
□ Fear of avoidance	□ Substance use	□ Gender
□ Discrimination	□ Legal problems	□ Romantic break-up
□ Traumatic event	□ Family problems	□ Divorce
□ Accident or injury	□ Suicidal thoughts	

□ Recent changes in life Briefly describe your reason(s) for seeking therapy now:

_____

_____

_____

_____

Thank you! Please have your credit card and photo ID ready for Alexis Cleckner, LPC records. Please also provide your insurance card if you're planning to file a claim for your sessions.

↓ Please leave this section blank ↓

Hx of PP and curr. sxs

Soc. hx/supp./coping

Fam of origin/Devel. Hx

Trauma/IPV/SA

SU

Sleep App

SI/HI

Goals