# Holly St.Pierre Counseling M.S Ed., LPCC

***HRS Counseling Services, LLC***
***52 Bellbrook Plaza***
***Bellbrook, Ohio 45305***
*Phone: (937)608-4204*
*www.hrscounseling.com*

*Struggles Today, Victories Tomorrow*

Please fill out this form as the client and bring it to your first session. Please note: Information you provide here is protected as confidential information.

Client Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Home Phone: May we leave a message? □ Yes □ No

Cellphone: May we leave a message? □ Yes □ No

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

EMERGENCY INFORMATION:
Emergency Contact: _____Phone_____
Relationship to Patient_____

**MINORS AS CLIENTS:**

Name of parent/guardian:
_____ Phone Number: _____ Profession: _____
(Last) (First) (Middle Initial)

Name of parent/guardian:
_____ Phone Number: _____ Profession: _____
(Last) (First) (Middle Initial)

Parents are… □ Biological □ Adoptive □ Married □ Separated □ Divorced □ Widowed

Name of Step-parent:
_____ Phone Number: _____Profession: _____
(Last) (First) (Middle Initial)

Name of Step-parent:
_____ Phone Number: _____Profession:_____
(Last) (First) (Middle Initial)

Adult Client Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age:
_____
_____

Who lives in the home with you (Name, age, relationship to client): In each home

_____
_____
_____
_____

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Newsletter: □ No Thank You
Please include my email on your monthly newsletter.
Signature: _____ Date_____

Referred by (if any): _____
May we contact them to say thank you for the referral? □ Yes □ No
Name:
Address:
Phone Number:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner_____

Are you currently taking any prescription medication? □ No □ Yes

Please list: _____

Have you ever been prescribed psychiatric medication? □ No □ Yes

Please list and provide dates: _____

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes: If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes: If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No □ Yes: If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes: If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced?

**FAMILY MENTAL HEALTH HISTORY**:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| ADHD | yes/no | |
| Bipolar Disorder | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |

**ADDITIONAL INFORMATION:**

1. Are you currently employed/grade in school? □ No □ Yes
If yes, what is your current employment situation or name of school?

_____

Do you enjoy work or school/Why?_____

Is there anything stressful about your current work/school?

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

4. What do you consider to be some of your weaknesses?

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____