Behavioral Health Consulting Services, LLC

www.bhcsct.org **infohealth@bhcsct.org**

46 West Avon Road
Suite 202
Avon, CT 06001

322 Main St.
Suite 1-G
Willimantic, CT 06226

530 Middlebury Road
Suite 103 B
Middlebury, CT 06762

Office phone- 1-860-673-0145 Office fax- 1-860-673-1255 Business fax-1-860-482-0737

CLIENT INFORMATION

Date_____

Client Name_____

Address_____

City _____ State _____ Zip_____
Home Phone _____ Work _____ Cell _____
May we leave a message: yes no

Email address: (To receive our newsletter we need your permission please check box) yes no

Birth Date_____ Gender _____ Age _____

Marital Status: Single Never married Married Divorced Widowed Separated

Occupation_____

Employer/School_____

Spouse's Name _____
Spouse's DOB_____
If client is a minor, parents' name(s) and address (s)
_____
Who referred you? _____

Emergency Contact Name _____Phone#_____ Relationship
_____

Behavioral Health Consulting Services, LLC

PSYCHIATRIC AND MEDICAL HISTORY

Client's physician and psychiatrist (list names, titles and phone #'s)

_____

_____

_____

Indicate any relevant medical history, including hospitalizations

_____

_____

_____

_ _____

Have you had previous psychotherapy? No Yes,

(previous therapist (s) name include phone #'s)

Are you currently taking any medications?

If yes, please list:

_____

Have you in the past taken any? Yes No

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good
2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

   _____
3. Are you having any problems with your sleep habits?
   No Yes
   If yes, check where applicable:
   Sleeping:

☐ too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams

☐ Other _____

Behavioral Health Consulting Services, LLC

CONTINUATION OF HEALTH AND SOCIAL

4. How many times per week do you exercise? _____
5. Approximately how long each time? _____
6. 5. Are you having any difficulty with appetite or eating habits?

☐ No ☐ Yes

If yes, check where applicable:

☐ Eating less
☐ Eating more
☐ Binging Restricting

7. Have you experienced significant weight change in the last 2 months?

☐ No ☐ Yes

8. How much caffeine, if any, do you have per day? _____
9. Do you smoke? No ☐ Yes ☐

If so, how much? _____

10. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

11. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

12. Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

13. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, how long have you been in this relationship?

_____

14. On a scale of 1-10, how would you rate the quality of your current relationship?

_____

15. In the last year, have you experienced any significant life changes or stressors:

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? C No C Yes If yes, what is your faith?

_____ If no, do you consider yourself to be spiritual? C No C Yes

_____

Behavioral Health Consulting Services, LLC

HAVE YOU EVER EXPERIENCED THE FOLLOWING

(please circle yes or no)

- Extreme depressed mood yes no
- Wild Mood Swings yes no
- Rapid Speech yes no
- Extreme Anxiety yes no
- Panic Attacks yes no
- Phobias yes no
- Sleep Disturbances yes no
- Hallucinations yes no
- Unexplained losses of time yes no
- Unexplained memory lapses yes no
- Alcohol/Substance Abuse yes no
- Frequent Body Complaints yes no
- Eating Disorder yes no
- Body Image Problems yes no
- Repetitive Thoughts (e.g., Obsessions) yes no
- Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes no
- Homicidal Thoughts yes no
- Suicide Attempt yes no

Occupational Information:

Are you currently employed? No Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any:

_____

_____

_____

Behavioral Health Consulting Services, LLC

FAMILY MEMBERS MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

- Difficulty Family Member yes No
- Depression yes No
- Bipolar Disorder yes No
- Anxiety Disorders yes No
- Panic Attacks yes No
- Schizophrenia yes No
- Alcohol/Substance Abuse yes No
- Eating Disorders yes No
- Learning Disabilities yes No
- Trauma History yes No
- Suicide Attempts yes No

Please list all who currently live in client's home Name Sex Age Relationship Occupation

_____

_____

_____

Behavioral Health Consulting Services, LLC

PRE-SCREENING TRAUMA SYMPTOM CHECK

HAVE YOU EVER EXPERIENCED THE FOLLOWING:

FOR CHILD OR YOUTH—AGE 4 TO 18 YRS

(Please circle the following yes or no)

Have you ever had anything bad happen to you? Yes No Maybe
(If you answer yes or maybe to the above question please answer the following questions below)

1) Have you ever been in a place that makes you really scared?
   Yes No
2) Do you try to stay away from people, places, or things that may remind you of this scary place?
   Yes No
3) Do you feel upset most of the time related to this?
   Yes No
4) Do you feel alone and not close to people around you?
   Yes No
5) Are you angry or irritable?
   Yes No
6) Do you have nightmares or bad dreams?
   Yes No

If you are experiencing the above symptoms- Please speak to your therapist about further screening tools for Trauma related symptoms and treatment.

Behavioral Health Consulting Services, LLC

REASONS FOR SEEKING COUNSELING

(Please provide answers below)

_____
_____
_____
_____
_____
_____

OTHER INFORMATION:

What do you consider to be your strengths?_____
_____

What do you like most about yourself?

_____
_____

What are effective coping strategies that you've learned?

_____
_____

What are your goals for the therapy?

_____
_____

Behavioral Health Consulting Services, LLC

INSURANCE INFORMATION

(PLEASE PROVIDER COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD)

Primary insurance company (name, address and phone #)

_____
_____
_____
_____

Name of person insured

_____
_____

DOB of person insured

_____

Members ID#

_____
_____

Behavioral Health Consulting Services, LLC