SILVERLEAF COUNSELING SERVICES

877 Baltimore Annapolis Road
Suite 303
Severna Park , MD 21146

PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Partner/Spouse Name (if applicable)_____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Birthplace: _____ Gender: ☐Male ☐Female

Occupation: _____ Employer: _____ _____ Years: _____

MEDICAL HISTORY

Family Physician: _____ OB/GYN_____

Specialist: _____ Specialist: _____

Complications w/pregnancy_____

Expected due date (if applicable)_____ Date of last sonogram_____

Are you currently taking any prescription drugs: ☐ Yes ☐ No

Name: _____ Dosage: _____ Purpose:_____

Name: _____ Dosage: _____ Purpose:_____

Name: _____ Dosage: _____ Purpose:_____

Do you use non-prescription drugs: ☐ Yes ☐ No

Name: _____ Dosage: _____ Purpose:_____

Name: _____ Dosage: _____ Purpose:_____

COUNSELING HISTORY

Have you ever received counseling before? ☐Yes ☐No

If yes, for what: _____ When:_____ Was it helpful: ☐Yes ☐No

Have you ever been treated for depression? ☐Yes ☐No

If yes, please describe: _____ When:_____ Was it helpful: ☐Yes ☐No

Have any family members ever had counseling? ☐Yes ☐No

If so, for what: _____ How long: _____ Was it helpful: ☐Yes ☐No

Is there any family history of drug/alcohol abuse? ☐Yes ☐No

If so, who: _____ Treatment was received: ☐Yes ☐No

Is there any family history of sexual or physical abuse? ☐Yes ☐No

If so, who?: _____ Treatment was received: ☐Yes ☐No

Is there any family history of suicide? ☐Yes ☐No

Continued on other side

FAMILY HISTORY

Relationship Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Separated ☐Widowed

Spouse/Partner
Name: _____ Years together: _____ Living: ☐At home ☐Away ☐Deceased: _____

Children:
Name: _____ Age: _____ Living: ☐At home ☐Away ☐Deceased: _____
Name: _____ Age: _____ Living: ☐At home ☐Away ☐Deceased: _____
Name: _____ Age: _____ Living: ☐At home ☐Away ☐Deceased: _____

Parents:
Name: _____ Age: _____ Marital Status: _____ ☐Living ☐Deceased: _____
Name: _____ Age: _____ Marital Status: _____ ☐Living ☐Deceased: _____

Siblings:
Name: _____ Age: _____ Marital Status: _____ ☐Living ☐Deceased: _____
Name: _____ Age: _____ Marital Status: _____ ☐Living ☐Deceased: _____
Name: _____ Age: _____ Marital Status: _____ ☐Living ☐Deceased: _____

SPIRITUAL AND EMOTIONAL SUPPORT SYSTEMS

Are you currently a member of or active in a faith community: ☐Yes ☐No

Faith/spiritual tradition raised in: _____ Faith/spiritual tradition practiced: _____

With whom do you live: _____

Please complete the following:

When I am sad, I talk to _____

I know I can count on _____

I draw hope from: ☐family ☐friends ☐faith/spiritual community ☐God ☐religion ☐inspirational readings ☐Other: _____

My main support is/are: ☐family ☐friends ☐faith/spiritual community ☐prayer ☐Other: _____

I believe I am involved in meaningful activities (work, volunteering, church, etc.): ☐Yes ☐No

I have appropriate outlets to express difficult feelings: ☐Yes ☐No ☐Uncertain

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Phone Numbers: ☐ Home _____ ☐ Work _____ ☐ Cell _____

CURRENT FUNCTIONING

Appetite: ☐Less than usual ☐No change ☐More than usual ☐Uncertain

Sleep Patterns: ☐Sleeping less than usual ☐No change ☐Sleeping more than usual every day ☐Uncertain

Feeling sad or empty: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Feeling fatigued or low energy: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Diminished ability to think or concentrate or indecisiveness nearly every day: ☐Yes ☐No ☐Uncertain

Having recurring thoughts of suicide: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Reduced interest or pleasure in all or most activities: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day

By Signing below, you agree that you voluntarily choose to participate in counseling. SilverLeaf Counseling practitioners reserve the right to decline offering treatment if the presenting issues are deemed to be beyond the scope of the professional practice.

(Signature)_____(Date)_____