Sacred Space Counseling Center DFW
800 Airport Freeway, Suite 745
Irving, Texas 75062

ADULT INFORMATION

Date: _____

Legal Name: _____

Preferred Name: _____

Please circle one: MALE FEMALE TRANSGENDER

Date of Birth:_____ Social Security:_____

Home Phone:_____ Cell Phone: _____

Work Phone: _____

Home Address: _____

City: _____ Zip: _____

Email Address: _____

Occupation: _____ Education: _____

Marital Status: _____

Please circle where we may leave a voice message: Home Work Cell
May we contact you by email? Yes _____ No _____
May we contact you by text message? Yes _____ No_____
I understand that while an email or text is confidential, there is no way for us to ensure the privacy from third parties. Due to the possibility that private information might be intercepted, please sign below for your permission for us to contact you via text/email for appointments only. We will not discuss clinical information by these mediums.
If you desire to receive communication about appointments by text or email, initial here. _____
If we have your permission to mail information to your home address, please initial here. _____
Current Employment Status: _____
Place of Employment (if applicable): _____

In the Event of an Emergency

Emergency Contact: _____Relationship to you: _____

Home Phone: _____ Alternate Phone: _____
Home Address: _____

City: _____ Zip: _____

Health Information

Please circle one of the following words to indicate your current level of health:
Very good Good Average Declining
Recent Weight Changes: Yes _____ No _____ N/A _____
List any present or past illnesses or injuries:

_____

_____

Are you currently taking any medications?: Yes _____ No _____
Please list any current medications:

Are you currently being treated for any medical conditions? Yes _____ No _____
Are you currently using any substances for anything other than medical purposes? Yes _____ No _____
If so, please list: _____

Have you ever experienced a profound emotional upset? Yes _____ No _____
If yes, please explain: _____

Mental Health Information

Have you previously received psychotherapy or counseling? Yes _____ No _____
If yes, please list the counselor and approximate dates: _____

Please briefly describe your experience (was it effective/outcome): _____

Are you currently receiving any mental health services? Yes _____ No _____
If yes, please list the name of the practitioner and the type of service you are receiving: _____

Is there any history of psychiatric illness in your family? Yes _____ No _____
If yes, please list the type and relationship: _____

Please check all the symptoms that you consider to be problematic:

__ Distractibility
__ Hyperactivity
__ Impulsivity
__ Boredom
__ Sleep problems
__ Fear
__ Sadness/depression
__ Loss of pleasure
__ Hopelessness
__ Helplessness
__ Self-harming behaviors
__ Irritability/anger
__ Loneliness
__ Work/school problems
__ Fatigue
__ Disturbing memories
__ Change in appetite
__ Lack of motivation
__ Withdrawal from others
__ Anxiety/Worry
__ Panic Attacks
__ Seasonal Depression
__ Social Discomfort
__ Gambling problems
__ Computer Addiction
__ Thoughts of death
__ Pornography Addictions
__ Parenting problems
__ Homicidal thoughts
__ Low self-worth
__ Guilt/Shame
__ Alcohol/Drug Use
__ Suspicion/paranoia
__ Racing thoughts
__ Excessive energy
__ Extreme mood swings
__ Poor memory/confusion
__ Nightmares
__ Eating problems
__ Obsessive thoughts
__ Compulsive behaviors
__ Aggression/fighting
__ Sexual problems
__ Crying spells
__ Flashbacks
__ Hearing voices
__ Visual Hallucinations
__ Irrational Behaviors

Are any of your issues affecting the following things?

__ Handling everyday tasks
__ Work/school
__ Recreational activities
__ Hygiene
__ Housing
__ Health
__ Self-esteem
__ Legal matters
__ Sexual Activity
__ Relationships
__ Finances

Have you ever received a psychiatric diagnosis? Yes _____ No _____
If yes, please list: _____
Have you ever or are you currently engaged in self-harming behaviors? Yes _____ No _____
Have you ever or are you currently having thoughts of hurting yourself? Yes _____ No _____
Have you ever attempted suicide? Yes _____ No _____
If so, please explain when and how:

Have you ever or are you currently having issues with sleep? Yes _____ No _____
If so, please describe: _____

Are you currently experiencing any changes in your appetite? Yes _____ No _____

If so, please explain: _____
Briefly describe what circumstances encouraged you to seek counseling at this time**:**

_____

_____

What are some goals that you hope to accomplish through the therapeutic experience?

_____

_____

What/who are your current support systems? _____

_____

_____

Marriage and Family Information

Name of Spouse/Partner: _____ Years Together: _____
Phone: _____ Occupation: _____
Spouse's Highest Level of Education Achieved: _____
Is your partner willing to attend counseling? Yes _____ No _____
Are you currently living with your partner/spouse? Yes _____ No _____
Are you currently experiencing difficulties in your relationship? If so, briefly describe: _____

_____

_____

Do you have children? Yes _____ No _____
Please list the names and ages of your children:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Will any of your family members be participating in the counseling sessions with you? Yes _____ No _____

Childhood Information

Name and Age of Mother: _____
Name and Age of Father: _____
Name and Age of Siblings: _____

_____

_____

Please circle the word that best describes your parent's marital status: Married Separated Divorced
Who did you live with growing up?: _____
Have any members of your family ever experienced any of the following? (If so, please note relation to self)
Physical Abuse: _____ Emotional

Abuse:_____

Homelessness: _____

Neglect:_____

Accident or Injury: _____ Sexual Abuse:

_____

Eating Disorder: _____ Substance Abuse: _____

Suicide: _____ Drug Abuse: _____

Have you ever experienced any of the following types of trauma or loss?

__ Emotional abuse	__ Neglect	__ Physical Abuse	__ Sexual Abuse
__ Multiple Moves	__ Family Violence	__ Crime Victim	__ Parental Substance Abuse
__ Homelessness	__ Teen pregnancy	__ Long-term Illness	__ Loss of a loved one

Legal Information

Have you ever been the victim of a crime? Yes _____ No _____
If yes, please explain: _____

_____
_____

Are you involved in a divorce or a child custody proceeding? Yes _____ No _____

If yes, please explain: _____
_____

Military Service

Have you been or are you currently in the military? Yes _____ No _____
If so, what branch? _____
Rank: _____ Discharge: _____
Were you in combat? _____

What type of activities do you most enjoy?

_____
_____

What personal qualities do you most appreciate in yourself?

_____
_____

Who are some of the influential and supportive people in your life?

_____
_____

Do you consider yourself spiritual? Yes _____ No _____
If you would like to share some of your guiding beliefs with me, please feel free to do so here:

_____
_____