Leeds Counseling, LLC
Julie Kizer, EdS, LPC, NCC, RPT
1200 6th Street
Leeds, AL 35094

GENERAL INFORMATION

Client Name: ____ DOB: __________

Address:____

City: _________________________________ State: ________ Zip Code: _____________

Telephone (where messages can be left): _________________________________

Email: _______________________________________

Employer: ____

Occupation: ____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____

Emergency Contact Relationship to Client: ____

Emergency Contact Telephone: _____________________________________

*Please note during an emergency, the emergency contact person listed, mobile crisis units, or 911 may be contacted.

RELATIONSHIP & FAMILY HISTORY

What is your current relationship status? (circle one)

Single   Married (years ______)   Separated   Divorced   Widowed

Do you have any children? No   Yes   If yes, Name(s) and Age(s):

____

MEDICAL/MENTAL HEALTH HISTORY

Present Medical Conditions (e.g., diabetes, allergies, disabilities): ____________________________

____

History of medical (non-psychiatric) hospitalization? No Yes If yes, please indicate year and

reason: ____

History of psychiatric hospitalization? No Yes If yes, please indicate year and reason:

____

Are you under care of a psychiatrist? No Yes If yes, please indicate provider name:

____

Are you taking any prescription medications (psychiatric or otherwise)? No Yes

If yes, indicate Condition, Name of Medication, Dosage, and any Present Side Effects:

____

____

Indicate Name of Prescribing Physician: ____

CURRENT CONCERNS

What is happening in your life that resulted in this appointment?

____

____

____

____

What would you like to see accomplished in counseling? ___________________________________

____

____

COUNSELING HISTORY

Have you been in therapy before? No Yes If yes, please describe the precipitating factors leading to seeking out care in the past. ____

____

What could be different this time to make the counseling experience better?

____

____

LIFE EXPERIENCES

Have you ever thought about committing suicide? No Yes If yes, please briefly describe what you experience: ____

____

Have you ever attempted suicide? No Yes If yes, please briefly describe any attempts including any medical care received: ____

____

Have you hurt yourself on purpose (Cutting, Burning, Hitting, etc.)? No Yes If yes, please briefly describe what you experience including medical care received: ________________________

____

Have you experienced or witnessed emotional abuse (e.g., chronic discord, yelling, screaming, cursing, name calling, demeaning language, financial control)? No Yes If yes, please briefly describe your experience as well as any medial or legal involvement:

____

____

____

Have you experienced or witnessed physical abuse (e.g., hitting w/hands or other object; pushing; withholding food, water, sleep)? No Yes If yes, please briefly describe your experience as well as any medial or legal involvement: ____

____

Have you experienced or witnessed sexual abuse (e.g., sexual harassment, inappropriate touching, rape, incest, etc.)? No Yes If yes, please briefly describe your experience as well as any medial or legal involvement: ____

____

Do you currently or have you in the past struggled with abuse or dependency of alcohol or drugs? No Yes If yes, please briefly describe your experience (e.g., substance type used, duration of use, amount of use): ____

____

Do you currently have any legal matters in your life? No Yes If yes, please briefly describe your experience: ____

____

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight/ Rare** Less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
I. Depression	1. Little interest or pleasure in doing things?	0	1	2	3	4
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4
II. Anger	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
III. Mania	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
IV. Anxiety	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
	7. Feeling panic or being frightened?	0	1	2	3	4
	8. Avoiding situations that make you anxious?	0	1	2	3	4
V. Somatic	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
VI. Suicidal	11. Thoughts of actually hurting yourself?	0	1	2	3	4
VII. Psychosis	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
VIII. Sleep	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4
IX. Memory	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
X. Repetitive	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
XI. Dissociation	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XII. Personality	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4

	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
XIII. Substance	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4
DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure, Adult. A rating of 2 or higher may indicate an area for additional consideration.						