Family Enrichment Center of Seattle
10564 Fifth Avenue N.E., Suite 405 Seattle, Washington, 98125 USA
Tele 206-306-9026 Fax 206-306-9631

Confidential Application for Counseling Services

I. Basic Information

Full name _____ m/f _____ Date _____

Address _____
street apt # city state zip
Phone (day) _____ (evening) _____ (message) _____
Email _____

Date of Birth _____ Age ____ Birthplace _____

Social Security Number _____

Whom should we contact in case of emergency?
Name _____ Relationship _____
Address _____ Phone _____

Who referred you to David Calof? (if not referred, how did you find out about our services?)
_____
_____

Did anyone else suggest you get help? _____

Is English your first language? [ ] Yes [ ] No If no, please indicate your first language?
_____

Ethnic or cultural identification _____

II. Current Situation

A. What do you wish to achieve through counseling? Describe 1) the condition that prompted you to seek counseling and 2) the outcome you seek) _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(please turn page if more room is need)

B. Symptoms

In the last six months, which of the following have you experienced?

[ ] Sleeping too little
[ ] Difficulty in falling asleep
[ ] Difficulty in staying asleep
[ ] Difficulty waking up
[ ] Sleeping too much
[ ] Thoughts about harming self
[ ] Frequent nightmares or disturbing dreams
[ ] Significant weight loss
[ ] Significant weight gain
[ ] Difficulty remembering
[ ] Increase in anxiety
[ ] Trouble controlling anger
[ ] Difficulty handling financial affairs
[ ] Feelings of numbness
[ ] Increase in feelings of misery
[ ] Increase in mood fluctuations
[ ] Recurrent intrusive memories
[ ] Thoughts about harming someone else
[ ] Feelings of despair
[ ] Sexual difficulties
[ ] Concern about sexual identity
[ ] Headaches, stomach pain, or other symptoms which might be stress-related
[ ] Increase in social isolation
[ ] Loss of appetite

Below, please feel free to add anything you think would be useful, or describe what you think accounts for the above mentioned signs and symptoms _____
_____
_____
_____
_____
_____
_____

III. Current Employment Situation

[ ] Unemployed
[ ] Employed part-time
[ ] Employed full-time
[ ] Self-employed
[ ] Work as home-maker/parent
Current occupation and/or description of work (if student, give year and major field)
_____
Usual occupation _____
[ ] Experiencing work-related difficulties
[ ] Student
[ ] Volunteer
[ ] On disability income or unable to work. Please give details _____
_____
_____
_____

IV. Family Information and Current Living Situation

Marital Status (please complete all that apply)

[ ] Single (never been married)
[ ] Married, living with spouse When married _____
[ ] Partnered, living with partner Since when _____
[ ] Married but separated. When married _____ When separated_____
Spouse's name _____
[ ] Divorced. When married _____ When divorced_____
Spouse's name _____
[ ] Divorced. When married _____ When divorced_____
Spouse's name _____
[ ] Divorced. When married _____ When divorced_____
Spouse's name _____
[ ] Widowed. When married _____ When did spouse die _____
Spouse's name_____

Additional information regarding marital/couple.family status:
_____
_____
_____

Are you currently in a significant partnered relationship? [ ] Yes [ ] No
If yes, for how long?_____

Current living situation
[ ] Live with partner/mate
[ ] Live alone
[ ] Live with other adult(s)
[ ] Live with parent(s)
[ ] Live with child(ren)
[ ] Experiencing difficulties in living situation. Explain_____
_____
_____
_____
_____
_____

Parents, step-parents, foster parents, adoptive parents

Name Age Relationship City of residence Date deceased
_____
_____
_____
_____

Raised by (if other than birth parents) _____

_____

_____

Brothers and sisters

Name	Age	Relationship	City of residence	Date deceased

Children, step-children, adoptive children

Name	Age	Relationship	City of residence	Date deceased

Family Psychiatric History

Does anyone in your family (parents, siblings) have a history of the following?

	Yes	No	Relative
Schizophrenia	_____	_____	_____
Major Depression	_____	_____	_____
Manic Depression (bi-polar disease)	_____	_____	_____
Multiple Personality (DID)	_____	_____	_____
Undiagnosed Psychiatric Symptoms	_____	_____	_____

Details

_____

_____

_____

_____

_____

V. Psychosocial History

Are you currently receiving services from a mental health professional of any type? [ ] Yes [] No

Have you undergone any form of counseling, psychotherapy or psychiatric care? _____ If so, please provide the therapist's name, location, dates of treatment and circumstances that prompted the treatment _____
_____
_____
_____
_____
_____

Have any of the following events happened in your life

	Past year	2-5 years	More than 5 years ago	Age/Date
Serious illness				
Serious injury				
Major illness in family				
Death of mother				
Death of father				
Death of child				
Death of sibling				
Desertion by mother				
Desertion by father				
Mental illness of family member(s)				
Job or school change				

_____
_____
_____

Physical or emotional abuse _____
Violence in family _____
Sexual abuse _____
Incest _____
Rape _____
Victim of crime/violence _____
Involved as an adult in
a violent relationship _____
a verbally abusive relationship _____
a sexually abusive relationship _____
Suicide attempt _____
Major loss _____
_____
_____

Other stressful event(s) or major losses in last 2 years

_____
_____
_____

Please describe any items checked above _____
_____
_____
_____
_____
_____
_____

Education (mark all that apply)

____ No high school ___ Some high school ___ High school graduate (year ____)

____ Some college major(s) _____

____ College graduate major(s) _____year _____

____ Some post-graduate work major _____

____ Master's degree(s) major _____year _____

____ Doctorate degree major _____year _____

____ Vocational, trade school, technical training

Type _____certificate_____ year ____

Had learning difficulties in school [ ] Yes [ ] No
Had discipline or social problems in school [ ] Yes [ ] No
Please explain

_____
_____
_____

Other history

Served in military [ ] Yes [ ] No. Branch _____
Position & Rank _____ Station location _____
Dates _____ Type of discharge _____

Additional information

[ ] Been convicted of a criminal charge? Please give dates, verdict and sentencing details

_____
_____
_____
_____

[ ] Currently involved in the legal system? Please give details _____
_____
_____
_____
_____

[ ] Am currently involved with any social service agency (e.g., children's protective service, division of vocational rehabilitation, welfare, crime victim's compensation board, other). Please describe
_____
_____
_____
_____
_____

List hobbies or activities you like to do in your spare time that give you pleasure _____
_____
_____
_____
_____

List those things you've very much wanted to do but have never gotten around to giving yourself the time _____
_____
_____
_____
_____
_____

List three (3) words or phrases that describe you

(1) _____

(2) _____

(3) _____

Religious preference(s) _____

Parent's religious preference(s) _____

VI. Health & Medical Information

Exercise regularly? [ ] Yes [ ] No Number of times per week _____
Please describe the type(s) of activity _____
_____
_____

Smoke cigarettes? [ ] Yes [ ] No Cigarettes per day _____ Brand _____
How long have you smoked? _____
Quit smoking? When? _____

_____

Drink caffeinated coffee? [ ] Yes [ ] No Cups per day_____
Other caffeinated beverages (tea, soft drinks, etc.)? [ ] Yes [ ] No Cups per day____

Normal bed-time? _____ Normal waking time? _____
[ ] Wake rested [ ] Have frequent dreams or nightmares [ ] Wake frequently during the night. To your knowledge, have you ever sleep-walked? [ ] Yes [ ] No If so, please describe _____
_____
_____
_____
_____
_____

[ ] Use an aid
[ ] Hearing [ ] wheelchair [ ] cane/walker [ ] contact lenses/glasses
[ ] other
_____
_____
_____

Name of physician/clinic _____ location _____ phone _____ Date of last exam _____
Findings_____
_____
_____
_____
_____
_____

Height _____ Weight _____ When measured last? _____

Height/weight five (5) years ago _____/_____
Height/weight one (1) year ago _____/_____
Height/weight six mos. (6 mos) ago _____/_____
Height/weight one mo. (1) ago _____/_____

[ ] Consider eating habits adequate
[ ] _____ meals per day
[ ] Consider self overweight by _____ pounds
[ ] Consider self underweight by _____ pounds
[ ] Take diet pills or laxatives
[ ] Use other weight control techniques (Describe) _____
_____
_____
_____

Major operations, injuries, illnesses

List Doctor/hospital Year

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had or do you now have the following conditions

[ ] High blood pressure
[ ] Diabetes
[ ] Heart problems
[ ] Hepatitis
[ ] Convulsions/seizures
[ ] Epilepsy
[ ] Cancer
[ ] Chronic Headaches
[ ] Hearing problems
[ ] Memory problems
[ ] Back pain
[ ] Glaucoma
[ ] Asthma/breathing problems
[ ] Thyroid/gland problems
[ ] Visual problems
[ ] Speech problems
[ ] Walking/coordination problems
[ ] Gastro-intestinal problems
[ ] Sickle Cell Anemia
[ ] Kidney disease
[ ] Dizziness/fainting/blackouts
[ ] Sexually transmitted disease
[ ] HIV/AIDS
[ ] Head injury

Please describe any checked items above as well as any current or on-going medical concerns not named above

_____
_____
_____
_____
_____
_____

Does any close relative have a history of or now have

	Condition	**Relationship**
	High blood pressure	
	Diabetes	
	Heart problems	
	Hepatitis	
	Convulsions/seizures	
	Epilepsy	

	Cancer	
	Chronic Headaches	
	Hearing problems	
	Memory problems	
	Back pain	
	Glaucoma	
	Asthma/breathing problems	
	Thyroid/gland problems	
	Visual problems	
	Speech problems	
	Walking/coordination problems	
	Gastro-intestinal problems	
	Sickle Cell Anemia	
	Kidney disease	
	Dizziness/fainting/blackouts	
	Sexually transmitted disease	
	HIV/AIDS	
	Mental illness	

Describe

_____
_____
_____
_____
_____

WOMEN ONLY

Number of pregnancies _____ Number of living children _____
Number of miscarriages/abortions _____
Date of last breast exam _____
Date of last pelvic exam _____

List all medications taken currently and within the last six months

Name Dosage Physician Prescribed/taken for

_____
_____
_____
_____
_____
_____

Are you allergic to any foods or medication [ ] Yes [ ] No
List all substances you are allergic to

Name Reaction

_____
_____

Alcohol and Substance Use

[ ] Don't drink alcohol
[ ] Drink alcohol
  [ ] Less than once a month
  [ ] 1-3 times a month
  [ ] Once a week
  [ ] 2-3 times a week
  [ ] Every day
  [ ] Mostly beer
  [ ] Mostly wine
  [ ] Mostly liquor
  At one time drink
  [ ] 1 drink
  [ ] 2-3 drinks
  [ ] 4-6 drinks
  [ ] More than 5 drinks
[ ] Consider self alcoholic
[ ] Amount spent on alcohol per month _____
[ ] Age at first use of alcohol _____
[ ] Last use of alcohol _____
[ ] Alcohol related health problems _____
_____
[ ] Family members who have alcohol-related problems _____
_____
_____
[ ] Don't use non-prescribed or street drugs
[ ] Use drugs
  [ ] Less than once a month
  [ ] 1-3 times a month
  [ ] Once a week
  [ ] 2-3 times a week

[ ] Every day
[ ] Marijuana
[ ] Cocaine
[ ] Narcotics
[ ] Hallucinogens
[ ] Barbiturates
[ ] Other _____
_____

[ ] Consider self drug-addicted
[ ] Amount spent on drugs per month_____
[ ] Age at first use of drugs_____
[ ] Last use of drugs_____
[ ] Drug related health problems_____
[ ] Treated for alcohol or substance abuse _____
_____
_____
_____
_____

Family members who have drug-related problems _____
_____
_____
_____
_____

Have you ever been hypnotized before? [ ] Yes [ ] No. Describe the experience(s)
_____
_____
_____
_____
_____
_____

List five (5) words of phrases which describe your attitude toward hypnosis or hypnotherapy.

1.
2.
3.
4.
5.

As a child did you ever have an imaginary playmate? How long did you have this/these friends? Describe
_____
_____
_____
_____

I, _____, declare that the above statements and answers in this 13 page Confidential Application for Counseling are correctly recorded, complete, and true to the best of my knowledge and belief. I have asked any question I had regarding fees and payment policies and I have received, read, and signed a **Disclosure and Informed Consent for Counseling form.** I hereby give my permission to David L. Calof to counsel me and employ the techniques of this clinic in counseling me.

_____ _____
full legal name date

_____ _____
parent/guardian's signature (if under 18 years of age) date

Do not write below this line

I. BASIC INFORMATION **1**

II. CURRENT SITUATION **1**

A. WHAT DO YOU WISH TO ACHIEVE THROUGH COUNSELING? DESCRIBE 1) THE CONDITION THAT PROMPTED YOU TO SEEK COUNSELING AND 2) THE OUTCOME YOU SEEK) _____ _____ 1

B. SYMPTOMS 2

III. CURRENT EMPLOYMENT SITUATION **2**

IV. FAMILY INFORMATION AND CURRENT LIVING SITUATION **3**

MARITAL STATUS (PLEASE COMPLETE ALL THAT APPLY) 3
PARENTS, STEP-PARENTS, FOSTER PARENTS, ADOPTIVE PARENTS 3
BROTHERS AND SISTERS 4
CHILDREN, STEP-CHILDREN, ADOPTIVE CHILDREN 4
FAMILY PSYCHIATRIC HISTORY 4

V. PSYCHOSOCIAL HISTORY **5**

EDUCATION (MARK ALL THAT APPLY) 6
OTHER HISTORY 6

VI. HEALTH & MEDICAL INFORMATION **7**

HEIGHT _____ WEIGHT _____ WHEN MEASURED LAST? _____ 8
HAVE YOU EVER HAD OR DO YOU NOW HAVE THE FOLLOWING CONDITIONS 9
DOES ANY CLOSE RELATIVE HAVE A HISTORY OF OR NOW HAVE 9
LIST ALL MEDICATIONS TAKEN CURRENTLY AND WITHIN THE LAST SIX MONTHS 11
ALCOHOL AND SUBSTANCE USE 11

Updated: 2/3/19