

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 _____
Spouse's name _____
- 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
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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

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/breathing problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid/gland problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Walking/coordination problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gastro-intestinal problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Dizziness/fainting/blackouts |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> 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

<u>Name</u>	<u>Dosage</u>	<u>Physician</u>	<u>Prescribed/taken for</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any foods or medication [] Yes [] No

List all substances you are allergic to

<u>Name</u>	<u>Reaction</u>
_____	_____
_____	_____

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 or 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.

_____ date
full legal name

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

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

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