

G R A Y Wellness Consulting, LLC

Personal Information:

Today's Date: _____

Last Name: _____ First: _____ Middle Initial: _____

Birth Date: _____ Age: _____

What pronouns do you use to Identify yourself? _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May I leave a message? _____

Cell Phone: _____ May I leave a message? _____

EMAIL ADDRESS: _____

VENMO: _____

How did you hear about me?

Single _____ Married _____ Partnered _____ Divorced _____ Separated _____ Engaged _____

How Long _____

Spouse/partner's name: _____

Is your spouse/partner supportive of you seeking counseling? _____

Do you have children? _____ Ages: _____

Do they live with you? _____

Do you take care of any other individuals? _____ Elder parent? _____

EMERGENCY CONTACT:

Name: _____ Relationship to you: _____

Address: _____

Phone: _____

Are you Employed? _____

Highest Level of education: _____

Do you consider yourself to be spiritual or religious? _____

Support/Social Network: Do you have people in your life that provide you with support when in need? _____

Names & phone numbers

Primary Care Physician: _____ Phone: _____

Address: _____

Physical Exam: ____ within last year ____ within last 5 years ____ greater than 5 years

Overall Health: ☐ Good ☐ Fair ☐ Poor

Explain: _____

LIST OF MEDICATIONS:

_____ mg ____/day prescriber: _____
_____ mg ____/day prescriber: _____
_____ mg ____/day prescriber: _____

SUPPLEMENTS: _____

Other Physician: _____ Phone: _____

Address: _____

Physician: _____ Phone: _____

Address: _____

Medical Conditions: No Medical Conditions ____ please check

☐ Hearing problems ☐ Vision problems ☐ Asthma ☐ Birth Defects
____ Seizures ____ History of Head Injury ____ Concussion ____ Loss of Consciousness ____ Hypertension
____ Stroke ____ Diabetes ____ Cardiac ____ Thyroid ____ Cancer ____ Back problems ____ Fibromyalgia
____ Autoimmune Disorder ____ Not Listed

Surgery: ____ none ____ Recent Surgery: _____ ____ History of Multiple Surgeries

ALLERGIES: Food, Medications (list): _____

Do you smoke Cigarettes? ____ yes ____ No How many per day? _____

Do you drink alcohol? ____ yes ____ No

Do you take any non-prescribed (recreational) drugs? ____ Yes ____ No If yes, please indicate substances used in the past or present.

Substances	Amount of Use	Frequency of use	Are you concerned about your use?
Alcohol			
Marijuana			

Cocaine/ crack/ Meth.			
Inhalants			
Stimulants			
Hallucinogens			
Heroin/Opiates			
Prescription drugs (specify):			

Do you Eat 3 balanced meals per day? ____ Yes ____ No

Do you exercise? ____ Yes ____ No

Are you happy with your sleep routine? ____ Yes ____ No

Identifiable Stress: ____ Relationships ____ Family ____ Health ____ Financial ____ Employment ____ School Other stressors: _____

Significant Life Events (past or present): _____

Legal Problems: Do you currently or have you had legal problems in the past? Y N

Current P.O. _____ Phone: _____

Any restraining orders? _____ Are you court ordered to Counseling? ____ (Copy of order needed)

Have you ever set fires in the past? _____ Have you ever committed a sex crime? _____ Have you ever been convicted of a sex crime? ____ Have you ever had thoughts, plans, or attempted to hurt/kill another person? _____ Have you ever physically hurt someone? _____

Previous Psychological Counseling or psychiatric help? Please check all that apply.

____ Individual Counseling ____ Group/ Couples/ Family Counseling

____ Hospitalized for psychiatric Issues? If yes, when _____

Have you had thoughts, plans or attempted to hurt/kill yourself in the past? _____

Family History of Mental Health: Consider anyone blood related to you.

Please indicate if there is a family history of any of the following by placing a check mark:

____ Alcohol/ Substance Abuse ____ Domestic Violence ____ Sexual Abuse ____ Physical Abuse
 ____ Emotional Abuse ____ Suicide Attempt ____ Death by Suicide ____ Eating Disorder
 ____ Schizophrenia ____ Bipolar ____ Depression ____ Anxiety ____ Learning Disorders
 ____ ADHD/ADD ____ Dropping out of High School ____ Obesity

Do you have guns or weapons in the house? Yes or no If Yes, please give more details: _____

What do you consider your biggest strengths?

Why are you seeking counseling at this time? (please answer)

Alternative Treatments (specify which you have used in the past): ____ Chiropractor ____ Acupuncture ____ Reiki
____ Yoga ____ Meditation ____ Massage Therapy ____ Cranio-Sacral Therapy ____ Aromatherapy

Name of person **FILLING OUT FORM (if different from client)** _____

Relationship to client: _____