ST. RAPHAEL
COUNSELING

(Please Print) Today's date:_____

CLIENT INFORMATION (FOR ALL CLIENTS)

Client Name (First, Middle, Initial, Last)	Marital Status ☐ Single ☐ Married ☐ Divorced	Sex ☐ M ☐ F	Birth Date
Street Address	City, State and Zip Code		
Home/Cell Phone	Work Phone		
Occupation	Employer or School	Yearly Family Income	
Who Referred You to This Practice ?	Have you seen our Website? ☐ Yes ☐ No	Religious/Spiritual Denomination	
Email Address	Are you Interested in using prayer during Therapy? ☐ Yes ☐ No		
Any Pervious Counseling? With Whom? How Long?			
List All Medications That You Are Currently Taking.			
Emergency Contact	Relationship to the Client	Home/Cell Phone	

IF MARRIED

Spouse's Name (First, Middle Initial, Last)	Birth Date	Cell Phone
Occupation	Employer/School	Years Married

IF A MINOR

Mother's Name	Living at Home? ☐ Yes ☐ No	Home/Cell Phone
Father's Name	Living at Home? ☐ Yes ☐ No	Home/Cell Phone

OTHER INFORMATION

Please Describe the Primary Reason you are Seeking Counseling:

The following items are common concerns of individuals coming to St. Raphael's. Please check all that apply to you. This will help us serve you better. Answer as honestly as possible. You may discuss your answers in detail with your counselor.

_____My parents are divorced/separated.

_____I cannot talk to my family about my personal concerns and problems.

_____My relationship with my family is unsatisfactory.

_____My family is not emotionally close.

_____I am not happy with my living arrangements.

_____I do not have close friends I can talk to about personal issues.

_____I use alcohol/drugs:_____ times per week.

_____My social/dating life in not satisfactory.

_____There are sexual concerns I'd like to discuss.

_____I've had an unwanted sexual experience.

_____I am dissatisfied with my personal appearance.

_____I have felt like or have tried harming myself. (Past or Present)

_____I have felt like or have tried harming others. (Past or Present)

_____I do not handle stress well.

_____I have difficulty expressing my emotions.

_____I often get extremely angry.

_____At times, I have acted in a violent manner.

_____I am having academic or work problems.

_____I have suffered a recent death loss.

_____I have suffered a recent life loss. (e.g., relationship ending, job loss)

The above information is true to the best of my knowledge.

_____

Patient/Guardian signature *Date:*