The LifeWorks Group, P.A.
wefixbrains.com 214.357.4001
3303 Lee Parkway, Suite 102 Dallas, TX 75219
7015 Snider Plaza Drive, Suite 202 Dallas, TX 75205
1208 W. Magnolia Ave, Suite 200 Ft. Worth, TX 76104

WHO REFERRED YOU TO US? **TODAYS DATE:**

NEW CLIENT BIOGRAPHICAL INFORMATION

Name: Date of Birth: Age:

Address: City, State, Zip:

Phone: (Home) (Work) (Cell)

May we contact you at home? _____ Yes _____ No Would you prefer to be contacted at ____ home ____ work ____ cell?

Email Adress:

May we add you to our email list ___ Yes ___ No? Office: ____ Dallas ____ Ft. Worth

Military Status: _____ Active Duty _____ Veteren ____Retired

Occupation: Education:

Employer:

Address:

Marital Status: ___ Single _____In a Relationship ___ Engaged ___ Married ___ Separated

___ Divorced ___ Widowed ___ Co-Habitating

Squeeze's Name: Age:

Occupation: Employer:

Names & Ages of Children: Phone: (Work) (Cell)

Number of Marriages & Length of Each: Email Address:

Military Status: _____ Active Duty _____ Veteren ____Retired

Religious Practice As A Child: As An Adult:

Name of Current Place of Worship: Clergy's Name:

Address: Phone:

May we contact your place of worship about our services (counseling, groups, seminars, etc.)?

___ Yes but don't mention my name ___ Yes and you can mention my name ___ No way!

Emergency Contact:

Phone: (Home) (Work) (Cell)

Who referred you, or suggested that you come to seek counseling? Check all that apply.

_____ Self _____ Parent _____ Friend _____ Employer _____ Physician _____ Other

Please summarize the issues for which you are seeking help. If there is more than one reason, rank them in order.

1)

2)

3)

Circle the number that represents the severity of your concerns.

Not Severe 1 2 3 4 5 Very Severe

Family of Origin (Parents, Siblings):

Name	Age	Relationship

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental health issue? Please explain.

MEDICAL/EMOTIONAL HISTORY

Physicians Name: Phone:

Date of last Physical:

Can we let your physician know we are seeing you and about our services? ____ Yes ____ No

Please list any medical treatments & operations within the last year:

Please list all current illnesses: (allergies, ulcers, tensions, back problems, skin disorders, etc.)

Please list any prescription medications you have taken within the last six months, circle current medications:

Have you had any prior personal counseling? _____ Yes _____ No (If yes, please list therapists, dates, and addresses)

Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency, etc.?

_____ Yes _____ No (If yes, please list hospital, doctor's name and dates with a brief explaination)

Have you ever considered or attempted suicide? Please explain briefly.

Have you ever been sexually, physically, or emotionally abused? If so, by whom and how long ago?

Check any of the following problems that apply to you:

_____	Headaches	_____	Dizziness	_____	Fainting spells
_____	Heart Palpitations	_____	Poor appetite	_____	Bowel disturbances
_____	Fatigue	_____	Insomnia	_____	Nightmares
_____	Sedative use	_____	Problem with alcohol	_____	Tension/anxiety
_____	Panic attacks	_____	Tremors	_____	Depressed
_____	Thoughts of suicide	_____	Drug use	_____	Difficulty relaxing
_____	Difficulty making friends	_____	Lack of enjoyment in life	_____	Sexual problems

_____	Difficulty keeping a job	_____	Difficulty making decisions	_____	Legal Matters
_____	Inferiority feelings	_____	Poor home environment	_____	Financial problems
_____	Educational difficulties	_____	Feelings of loneliness	_____	Anger
_____	Problems with children	_____	Self-control problems	_____	Memory problems
_____	Career Choices	_____	Parenting issues	_____	Distractability
_____	Binge/Vomit/Laxative Use	_____	Loss of time/blackouts	_____	Hyperactivity
_____	Difficulty sitting	_____	Compulsive behavior	_____	Marital problems
_____	Racing Thoughts	_____	Divorce	_____	Separation

Briefly list what you think are your personal strengths and weaknesses. Think in terms of your personality, work habits, intellectual capabilities, and other skills or talents.

Strengths	Weaknesses

MARKETING INFORMATION

How did you hear about LifeWorks Counseling?

Who sent you to LifeWorks?

May we send them a thank-you card? ___ Yes ___ No

What prompted you to choose LifeWorks Counseling?

_____	Price	_____	Location
_____	Friend	_____	Philosophy of Counseling
_____	Reputation of Center	_____	Reputation of Counselor
_____	Other _____		

What type of seminars interest you?

_____	Relationships	_____	Depression	_____	Other: _____
_____	Anger	_____	Sexual Abuse		
_____	Marriage	_____	Spiritual Growth		
_____	Pre-marriage	_____	Parenting		

We are a training facility. Do you consent for a Masters Level Intern to observe your session? Yes____ No ____