Brittany L. Collins Ph.D., LPCC (OH), LPC-S (MO), LPC (TX), NCC
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Developing ME!
— counseling & consulting —

New Appointment Information

Please complete all items to help in planning services for you.
All information is kept confidential (see Notice of Privacy Practices).

Full Name: _____ Today's Date: _____

Preferred Name: _____ Pronouns: _____ Sex/Gender: _____

Date of Birth_____ Email Address: _____

Phone: _____ May we leave a message and/or text? Y N

Racial/Ethnic Background: _____ Country of Origin: _____

Occupation/Employer: _____ Education Level: _____

How did you find out about this service? _____

What brings you here today? _____

1. Has anyone expressed concern about your:

   _____Mood _____Risky Behavior _____Eating Behaviors _____Substance Use _____Other

2. Have you ever missed any practices/classes/work due to your presenting concerns? Y N

3. Are you engaging in self-harming behaviors? Y N

4. List all prescribed medications:

   _____
   _____
   _____

5. List any medications used that are not prescribed by a physician:

   _____
   _____
   _____

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6. During the past 2 weeks what is the average number of days you drank alcohol each week:

0 1 2 3 4 5 6 7

a. Average number of drinks on each occasion:
_____

7. Have you recently had a traumatic experience? Y N

8. Have you ever been physically, emotionally, or sexually abused? Y N

9. Are you engaging in any of the following eating related behaviors: Y N

If yes, Type? _____ (i.e., Binging/Uncontrolled Eating, Purging, Restricting food intake, Regular Use of Laxatives)

10. Has there ever been a period when you were not your usual self and….

a. _____You got much less sleep than usual and were not tired.

b. _____You were much more active or did many more things than usual.

c. _____You did things that other people might have thought were risky.

d. _____You experienced extreme mood changes.

11. Have you ever seen or heard anything that other people couldn't see or hear? Y N

12. Have you had unusual experiences that other people might not believe? Y N

13. Prior mental health treatment and approximate ages:

a. Psychologist/Counselor: _____
b. Psychiatrist: _____
c. Hospitalizations: _____
d. Medications: _____

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14. Do you have biological relatives with any of the following (please circle)?

Depression Anxiety Bipolar Alcohol/Drug Addiction ADHD Schizophrenia

15. Please describe in your own words why you are currently seeking counseling:

_____

_____

_____

_____

16. Family Background: Describe your past and current relationships with those who raised you and whom you grew up with?

_____

_____

_____

_____

17. How many siblings do you have?

_____ Sisters _____ Step-Sisters _____ Half Sisters

_____ Brothers _____ Step-Brothers _____ Half Brothers

18. Current Living Arrangements: Own Rent Live with Family / Friend

19. Number of People in Household: _____

20. Name of Household Members/Relationship/Age:

1. _____
2. _____
3. _____
4. _____

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PLEASE LIST A PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Telephone: _____

Relationship of contact person to client: _____

PHYSICIAN: Please provide the name, address, and telephone number of your personal physician or clinic: (they will not be contacted without your permission)

Name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Telephone: _____

_____ I do not currently have a personal physician or clinic to take care of my general health problems.

How would you describe your current physical health?

Excellent Good Fair Poor

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PLEASE CIRCLE ALL THAT PERTAIN TO YOU

STRESS	EATING PATTERNS	PURPOSE IN LIFE	PARTNERSHIP/MARRIAGE
RELAXATION	BINGEING	FITTING IN	BREAK-UP/DIVORCE
NERVOUSNESS	VOMITING	FRIENDS	PARENTING
ANXIETY	PURGING	LONELINESS	CHILDREN
FEARS	WEIGHT	RELATIONSHIPS	PARENTS
CHEST PAINS	DEPRESSION	SHYNESS	SEPARATION
MUSCLE TENSION	UNHAPPINESS	PHYSICAL CONTACT	GENDER ISSUES
HEADACHES	SLEEP PROBLEMS	SHAME	SEXUAL PROBLEMS
DIZZINESS	LOSS OF INTEREST	ABUSE	EDUCATION
NERVOUS TICS	WITHDRAWAL	FLASHBACKS	LEARNING DISABILITY
PALPITATIONS	APPETITE	DISSOCIATION	FINANCES
EXCESSIVE SWEATING	SELF WORTH	NIGHTMARES	WORK
EXCESSIVE THIRST	TIREDNESS	HURTING SELF	AMBITION
PHOBIC AVOIDANCE	BOREDOM	RISK TAKING BEHAVIOR	
HYPOCHONDRIASIS	MEMORY	ATTENTION DEFICIT	AVOIDANCE
COMPULSIONS	CONCENTRATION	EXCITEMENT SEEKING	LEGAL MATTERS
RITUALS	GUILT	DRUG/ALCOHOL USE	MY THOUGHTS
BOWEL TROUBLE	MAKING DECISIONS	SELF-CONTROL	MY BELIEFS
STOMACH TROUBLE	ENERGY	ANGER	FEELING UNREAL
HEALTH PROBLEMS	OVER FOCUSED	AGGRESSIVE BEHAVIOR	ODD BEHAVIOR
PAIN	INFERIORITY FEELINGS	TEMPER OUTBURSSTS	HALLUCINATIONS
SUICIDAL THOUGHTS	JEALOUS FEELINGS		HEARING THINGS
SUICIDAL PLANS	LOSS OF CONTROL		UNUSUAL EXPERIENCES
SUICIDAL BEHAVIOR	SUSPICIOUS OF OTHERS		DELUSIONS