Concordia Counseling & Behavioral Health Center Client Registration

Client's Last Name	First Name	MI
Social Security	Birth date//	_Age
Gender: F/M	Year in College:	
Client's Concordia/Seward Addres	ss	
City	State	_ Zip Code
Client's Permanent Address		
City	State	_ Z ip Code
Home Phone Work Phone	Cell Phone	
Is it OK to call you at: Home? □Yes	□ No Cell? □ Yes □ No	Work? □Yes □ No
Is it OK to contact you via email? If yes, please give email address: Have you ever received counseling/tr If yes, where/when/by whom		_
Did someone refer you to our office? If so, v	vhom?	
Presenting Problem (s): Briefly describe the problem (s) you assistance:	are encountering for which y	ou are seeking our
Medical History:		
Name of Family PhysicianAddress		
Date of last physical examination:		
Prescription and Non-Prescription Dr	rugs used in the last six mon	ths:

Do you have Allergies? Yes No If yes, to what?	
Do you use tobacco products? Yes No If yes, how much	
Do you use products with caffeine? Yes No If yes which products	
<u>Chronic Medical Conditions</u> / Serious Illness:	

Dates and reason for previous hospitalizations/surgeries/emergency room visits:

Current concerns/symptoms:

Circle any areas of your life or symptoms/problems you are currently experiencing:

- 1. I am unable to do the things I used to do.
- 2. I feel hopeless about the future.
- 3. I have a decreased need for sleep.
- 4. I can't make decisions.
- 5. I find it difficult to control my worrying.
- 6. I avoid or feel very uncomfortable in situations involving people such as dating or other social events.
- 7. I am terrified about being overweight.
- 8. I feel sluggish or restless.
- 9. I have a heightened interest in sex.
- 10. I become irritable or anxious.
- 11. I experience a sudden, unexplained attack of intense fear, anxiety or panic for no apparent reason.
- 12. I think about dying or killing myself.
- 13. I get tired for no reason.
- 14. My thinking is speeded up.
- 15. I feel extremely guilty after eating.
- 16. I am gaining or losing weight.
- 17. I have been afraid of not being able to get help or not being able to escape in certain situations.
- 18. I have gone on eating binges where I feel I may not be able to stop.
- 19. I am sleeping too much, or too little.
- 20. I can't keep my mind on one thing—I jump from task to task.
- 21. I feel unhappy.
- 22. I am irritable and short-tempered.
- 23. I can't seem to stop talking.

- 24. I have had an extremely frightening, traumatic or horrible experience like being a victim of a violent crime, seriously injured in a car accident, sexually assaulted, or seeing someone injured or killed.
- 25. I have vomited or had the impulse to vomit after meals.
- 26. I feel that food controls my life.
- 27. I spend more time than is necessary doing things over and over again, such as washing my hands, checking things, or counting things.
- 28. I have much more energy than usual.
- 29. I feel unusually euphoric and "high

My Goal(s) for therapy:

1.

2.