SANCTUARY COUNSELING

Please fill out fully and legibly before your first appointment.
If more space is needed, please utilize the last page to complete your thoughts

Name:	Date:	Time:	Sex:
Address:	DOB:	Age:	Gender:
City: Phone:	SS#:	Race:	
State: Zip: County:	Marital Status:		

Presenting Problem/Reason for seeking treatment:

Who currently lives with you? Do you have housing needs at this time?

School/Employment Status:

Mother/Guardian: Address: Phone:

Father/Guardian: Address: Phone:

Are you experiencing any current Legal issues (i.e. divorce, probation…):

Primary Care Physician:

Physical in the Last 12 Months?: YES NO

Psychiatrist / Medication Provider:

Medical Insurance/Medicaid Number:

HISTORY

(Include any available documentation for the following categories)

Medication Taken In the Past, Currently Prescribed or Taken Over the Counter:

1. Please list Past Medications and Dosages, were this medications helpful or unhelpful?
2. Current Medications and Dosages, are these medications helpful or unhelpful?
3. Over the Counter Medications/ Response

Medical History:

1. Personal:
2. Previous medical diagnosis:
3. Infections/ allergy:

4. Family:

Mental Health History:
Personal Psychiatric/ Diagnosis History:
Please list the diagnosis, the date diagnosed, and who made the diagnosis:

Family Psychiatric History:

Brief Trauma History:

Developmental History (*Indicate C=current problem/P=past problem*) Temperament Eating

Special Education Decision Making Communication Sensory

Repetitive behaviors Restricted Interests Body/Emotional Control

Sexual Behavior History:

Please list any sexual concerns that relate to your mental health:

Psychological, Psychiatric, and other Testing:

Date Completed:

Names and Dates of previous treatment and providers:

Agency and Clinician Names:

Dates and Treatment Types:

Names of Current Mental Health Providers/Clinician/s and Treatment Types

Agency and Clinician Names:

Start Date and Treatment Types:

What was your experience while working with Other Mental Health Providers?

Current Services:

Treatment:

Community Resources:

SUBSTANCE ABUSE

Substance Use History**:**

Substance Use Treatment**:**

Drugs of Choice: (*Indicate C=current/P=past*):

LSD PCP	crack crank speed	caffeine cocaine heroin opioids tobacco	inhalants marijuana morphine mushrooms alcohol	amphetamine benzodiazepine barbiturates methamphetamine prescription drugs	☐ None ☐ Unknown ☐Other: ________ _______________ _____

Current Substance Use/Dependence**:**

Family History of Drug/Alcohol Use *(check all that apply)*:

☐ Father: ☐ Mother: ☐ Siblings: ☐ Grandparent:
☐ Significant Other: ☐ Other: ☐ None ☐ Unknown

Comments**:**

Health/Medical
Do you feel this area is a_____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Vocational/Educational
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Financial
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Social Relationships/Support
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe

Explain:

Basic Living Skills
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Housing
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Community
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Legal
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Family & Family Participation
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Cultural (including Spiritual)
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Substance Use
Do you feel this area is a _____Strength _____Barrier _____Both _____Neither
Level of Impairment (circle 1): None Mild Serious Severe
Explain:

Risk Assessment:
1. Danger to Self (Please include past suicide attempts/methods of self-harm/ and current suicidal thoughts):

2. Danger to Others(Please list any attempts to harm others) :

List any learning needs & issues that might hinder participation in counseling:

Are you interested in participating in a Psychological Assessment: Yes No

Additional info:

Last Update – 3/17/2021