Gordon D. Hobbie, Ph.D., LMHC
LIC. # MH2710

Today's date__________________Referred by:____

GENERAL INFORMATION

Name:_____________________________________ Email Address ________________ @______________
(optional-For information about events, seminars &groups)

Age:_____ Date of Birth_________________ Sex: ❑ Male ❑ Female

Address: ____
(Street) **(May we send correspondence here? ❑ yes ❑ no)** (City) (State) (Zip)

Home Phone ______________________________ Alternate Phone__________________________________
(May we leave a message for you here? ❑ yes ❑ no) **(May we leave a message for you here? ❑ yes ❑ no)**

Employer:__________________________________ How long have you been there?__________________

Occupation:_________________________________ Average work hours per week: ___________________

Work Phone: ________________________________
(May we leave a message for you here? ❑ yes ❑ no)
{If the above phone numbers and/or addresses are not acceptable correspondence, please inform Dr. Hobbie.}

Last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Degree pursued/accomplished________

Are you currently in school? ❑ yes ❑ no If so, what level?_____________ Degree pursuing:____________
Whom may we contact in case of an emergency___________________________ Ph.# _______________
Would you like to be added to our Mailing List? Y N

RELATIONAL INFORMATION

Current Marital Status ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Are you content with your current status? ❑ yes ❑ no. If no, please explain__________________________
____
If married, for how long? ______Number of previous marriages for you______for your spouse_________

If separated, divorced, or widowed, circle and state for how long: ________________________

With whom do you currently live? ❑Alone ❑Spouse ❑Children ❑Parent(s) ❑Sibling(s) ❑Boyfriend ❑Girlfriend ❑Other (please specify)__________________________
(Check all that apply)

Partner Information: How long have you known your partner? ___________________

Name: ____ Age: ______________

Occupation: ____

Hours worked/week: _______ Last year of school completed: 9 10 11 12 GED College: 1 2 3 4 other

What words would you use to describe your partner: ____

____

Children (use back if needed):

Name	Sex	Relationship to you (Natural, adopted, step)	Living w/you?	Age	Describe him/her

Family of Origin Information (use back if needed).
(Please list mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect upon your life [either positive or negative]).

Name	**Relationship to you** Mom, dad, sibling, or step-children	Current age, or year of death	Occupation	Describe him/her

Please briefly describe your religious upbringing as a child:_______________________________________

____

PHYSICAL HISTORY

Name of Physician: ____ Phone: _________________________

Specialty (family practice, ob/gyn, internal medicine, etc.): ____

Address of Physician: ____
Are you currently receiving any medical treatment? ❑ no ❑ yes. If yes, please explain________________

____

Please list any other conditions, illnesses, treatments, or surgeries (including pregnancies, or related treatments) that might be relevant to your reason for seeking counseling: _________________________

____

Have you ever been hospitalized? ❑ yes ❑ no What was the cause?______________________________

Please list all current medications you are taking, and the reasons. (List even if you seldom use, or take only as needed.)

_________________________ _______ which improves/controls ______________________________
(Medication) (Dosage) (Reason)

__________________________ _______which improves/controls ______________________________
(Medication) (Dosage) (Reason)

Are you taking these medication(s) according to the doctor's recommendations? ❑Yes ❑ No.
If no, please explain: ____

Please check any of the following physiological symptoms/sensations that apply to you currently, or in the recent past:

❑ Headaches	❑ Rapid Heart Rate	❑ Dizziness	❑ Difficulty breathing
❑ Diarrhea	❑Allergies	❑ Nausea	❑ Insomnia
❑ Stomach trouble	❑ Intestinal trouble	❑ Visual trouble	❑ Hearing noises/voices
❑ Trouble with sleep	❑ Change in appetite	❑ Trouble relaxing	❑ Vomiting
❑ Weakness	❑ Tiredness	❑ Tension	❑ Pain-specify_____________
❑ Backaches	❑ Constipation	❑ High Blood Pressure	❑ Other __________________

Your height?____________ Your weight?___________Weight change in the last 2-3months ? ________

CURRENT STATUS

Please check any of the following problems that pertain to you and/or any members of your family (indicate if family members).

❑ Stress	❑ Nervousness	❑ Anxiety	❑ Panic
❑ Unhappiness	❑ Depression	❑ Guilt	❑ Apathy
❑ Terminal illness	❑ Recent death in family	❑ Grief	❑ Hopelessness
❑ Inferiority feelings	❑ Defectiveness feelings	❑ Loneliness	❑ Shyness
❑ Fears	❑ Friends	❑ Marriage	❑ Sexual abuse
❑ Physical abuse	❑ Emotional abuse	❑ Verbal abuse	❑ Bad dreams
❑ Temper	❑ Anger	❑ Aggressive behavior	❑ Memory
❑ Concentration	❑ Racing thoughts	❑ Unwanted thoughts	❑ Compulsivity
❑ Loss of control	❑ Impulsive behavior	❑ Self control	❑ Legal matters
❑ Sexual problems	❑ Pregnancy	❑ Abortion	❑ Alcohol use
❑ Trauma/disaster	❑ Eating problems	❑ Drug use	❑ Making decisions
❑ Trouble with job	❑ Career choices	❑ Ambition	❑ Communication
❑ Children	❑ Being a parent	❑ Finances	❑ Other ___________

Please indicate on the scale below how distressing your problem(s) are to you. Place an "X" on the line.

Distressed Very Little — Moderately Distressed — Extremely Distressed

Are you currently experiencing any suicidal thoughts? ❑ yes ❑ no
Have you experienced suicidal thoughts or attempted suicide in the past? ❑ yes ❑ no
Have any of your friends or family ever committed or attempted suicide? ❑ yes ❑ no

Check any of the following that apply to you:

❑ Marijuana	❑ Stimulants	❑ Coffee
❑ Sedatives	❑ Fitful sleep	❑ Narcotics
❑ Cocaine	❑ Overeating	❑ Hallucinogens
❑ Alcohol	❑ Tranquilizers	❑ Early morning awakening
❑ Cigarettes	❑ Painkillers	❑ Other

PRESENTING ISSUES AND GOALS:
Please describe why you are coming to counseling? (i.e., specific issues you want to address?)

____

____

____

What is it that you hope to gain or change by coming in for counseling?____________________

____

If you have had any previous counseling, psychiatric treatment, or residential/in-patient care, please list the dates, duration, and names of the therapists or programs: (use back if needed)

____

____

What words would you use to describe yourself?_______________________________________

____

Please describe your religious views as an adult:_______________________________________

____

Please describe briefly the religious environment of your home as you were growing up._______

____

Do you regularly attend a church, synagogue, or other religious institution? ❑ Yes ❑ No.
If so, what is the name of your church, synagogue, etc?__________________________________

If so, what is the name of your pastor, priest, rabbi, etc?________________________________

____ ______________________

(Signature of client) **(Date)**

{See attached Policy Letter for your signature for acceptance of the policies and the therapist signature}