



CLIENT INFORMATION

Patient's Name _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Mailing Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____

Sex: Female _____ Male _____ Date of Birth _____ Age _____

Single _____ Married _____ Divorced _____ Widowed _____ Seperated _____

Please list children and their ages: (if applicable)

Patient Employer _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Phone _____

Drivers License # _____

How or from whom did you hear of Restoration Counseling?

Physician Church/Pastor Friend Web Search Other

In Case of Emergency, contact _____ Phone _____

Physician _____ Phone _____

PARENT/SPOUSE INFORMATION

Spouse/Parent _____ Phone _____

Employer _____ Phone _____

Occupation _____ Social Security # _____

RELEASE OF INFORMATION

I authorize Restoration Counseling to obtain/release/exchange information with my Primary Care Physician or other healthcare practitioners for the purpose of service coordination and continuity of care.

Physician's/Other practitioners name _____

Address _____

Phone _____ Fax _____

Check here if you do not authorize this release of information _____

COMMUNICATION BETWEEN YOU AND RESTORATION COUNSELING

Occasionally it will be necessary for our office to contact you regarding appointments or other matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discrete in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your preferred contact phone number? (circle one)

Home _____

Cell _____

Work _____

If you need to make, change, cancel an appointment or have questions about your patient records or account, please call the Restoration Counseling office @ 904-412-2876.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

PATIENT HEALTH QUESTIONNAIRE

All information is kept confidential in adherence with current HIPPA regulations

Name: _____

Date: _____

People commonly encounter problems in the following categories. Please indicate how you are affected by each by circling the number that most accurately reflects your feeling.

Not a Problem	Slight Problem	Moderate Problem	Serious Problem	Severe Problem
0	1	2	3	4

<ol style="list-style-type: none"> 1. Feeling sad, depressed or unhappy 2. Feeling discouraged or hopeless 3. Feeling bad about yourself 4. Little interest or pleasure from things I usually enjoy 5. Feeling guilty, worthless, or helpless 6. Crying spells 7. Restless, irritable or agitated 8. Feeling tired or having little energy 9. Trouble falling or staying asleep, or sleeping too much 10. Poor appetite or overeating 11. Trouble making decisions 12. Difficulty with concentration 13. Less interest in sex 14. Thoughts that you would be better off dead, or of hurting yourself in some way. 	
<ol style="list-style-type: none"> 1. Anxious/nervous/worried 2. Stressed/overwhelmed 3. Intense fear, panic/discomfort 4. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.) 5. Anxiety about being in certain situations (such as in a crowd, traveling, standing in line, etc.) 6. Anxiety or fear related to being in social situations or having to Perform (such as public speaking, test taking, etc.) 7. Fear, anxiety, or avoiding specific situations (such as flying, Heights, animals, etc.) 8. Worrying about health problems 	
<ol style="list-style-type: none"> 1. Having unwanted thoughts over and over again 2. Repeating specific acts over and over (such as hand washing, Checking, etc.) or mental acts (such as counting, repeating words) 	

Not a Problem **Slight Problem** **Moderate Problem** **Serious Problem** **Severe Problem**
0 **1** **2** **3** **4**

<ol style="list-style-type: none"> 1. Euphoria (feeling high) 2. Sudden changes in mood for no apparent reason 3. Decreased need for sleep 4. More talkative than usual 5. Racing thoughts 6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.) 7. Excessive irritability or agitation 8. Angry outbursts 9. Property destruction 	
<ol style="list-style-type: none"> 1. Making careless mistakes at school, work or other activities 2. Difficulty sustaining attention during tasks 3. Difficulty following through or finishing things 4. Difficulty in organizing tasks or activities 5. Easily distracted 6. Losing things or forgetful 7. Hyperactivity (can't sit still) 8. Poor impulse control 	
<ol style="list-style-type: none"> 1. Hearing things 2. Seeing things 3. Experiencing confusion 4. Memory lapses/forgetting 5. Feeling of unreality or being outside of self 6. "Missing time" 7. Suspiciousness (questioning other people's motives) 	
<p style="text-align: center;">I have been experiencing these problems for:</p> <p style="text-align: center;"> < 1 month 1-6 months 7-12 months > 1 year </p>	

Check the following that have caused concern or difficulties during the last 6 months:

Taking care of personal grooming needs
 Getting along with spouse/parents/children
 Meeting financial obligations
 Meeting home responsibilities
 Enjoyment of work

Preparing meals for family/self
 Taking care of children/others
 Enjoying of hobbies
 Getting along with co-workers/others
 Meeting work responsibilities

Current Life Stressors

- Relationship issues (arguments, separation, divorce)
- Health issues (illness or injury)
- Financial issues (owe money, loss of job, unemployment)
- Abuse (physical, mental, emotional, sexual)
- Legal difficulties (law suit, traffic, criminal charges)
- Substance abuse (alcohol/drugs/food)

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___ Not at all ___ Somewhat ___ Very ___ Extremely

Briefly describe why you are seeking help at this time:

Please check below if you have had any of the following medical conditions:

- | | | |
|-----------------|---------------------|----------------------------|
| Arthritis | Diabetes | PMS |
| Stomach Ulcers | Head injury | Asthma |
| Hyperthyroidism | Seizures | Other Respiratory Problems |
| Hypothyroidism | Heart attack | Cancer |
| Kidney problems | Angina | Menstrual Problems |
| Colitis/Crohn's | High blood pressure | Pregnancy (___ times) |
| Chronic pain | Urinary retention | Miscarriage (___ times) |
| Lupus | Migraines | Hysterectomy |
| Tuberculosis | Chronic headaches | Surgery:_____ |
| Other:_____ | | |

Please list all current medications:

Medication	Strength	Frequency	Date Started	Prescribed by

Please list all previous psychotropic medications you have ever taken:

Medication	Strength	Frequency	Date Started	Prescribed by

Medication Allergies: No ___ Yes ___ (Describe: _____)

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations

Dates	Reason	Counselor/Doctor

Yes ___ No___ Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?

Yes ___ No ___ Has any family member ever had any history of depression, anxiety, other mental problems, or suicide? If so, who and what?

Yes ___ No ___ Never ___ 1. Do you have thoughts about suicide now?

Yes ___ No ___ Never ___ 2. Have you ever thought about suicide?

Yes ___ No ___ Never ___ 3. Have you ever attempted suicide?

Yes ___ No ___ Never ___ 4. Do you have access to guns/weapons?

Yes ___ No ___ Never ___ 1. Are you thinking about hurting someone now?

Yes ___ No ___ Never ___ 2. Have you ever thought about hurting someone else?

Yes ___ No ___ Never ___ 3. Have you ever hurt someone else?

Please answer the following questions:

Do you drink alcoholic beverages? Yes No Never

If never, please skip to the next section.

If yes, how many alcoholic drinks do you have in the average

Day _____ Week _____ Month _____ Year _____

If yes to the above, please answer the following:

Yes ___ No ___ Have you ever sought help for alcohol or drug use?

Yes ___ No ___ In the past year, have you ever drunk alcohol or used drugs more than you meant to?

Yes ___ No ___ Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

Yes ___ No ___ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Yes ___ No ___ Have anyone ever objected to your drinking or drug use?

Yes ___ No ___ Have you ever found yourself preoccupied with wanting to use alcohol/drugs?

Yes ___ No ___ Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

Yes ___ No ___ Has your drinking or drug use ever caused legal problems (DUI's, Violence)?

Check if you have taken any of the following drugs:

Yes ___ (which ones) No ___

If No, please skip to the next section.

Marijuana/Pot

Cocaine/Crack

Inhalants

Amphetamines/Speed

Barbituates/Sedatives/Downers

Designer drugs, Ecstasy

Heroin/opiates

Intravenous drug use

Tranquilizers (Xanax, Valium)

PCP/Angel Dust

Pain medicine

LSD/hallucinogens

Have you ever taken prescribed medication inappropriately? Yes ___ No ___

Sleep Difficulties (Check all that apply):

None

Wets bed

Nightmares

Falling asleep

Walks in sleep

Bad dreams

Falling back to sleep Snores
Tired upon waking Stops breathing during sleep
Early morning awakening Falls asleep when emotional

Usually, the time that I...

Go to bed: _____ A.M. _____ P.M.

Wake up: _____ A.M. _____ P.M.

Smoking:

None

Packs per day: 1 2 3 Other

Age began:

Caffeine (cups per day):

Coffee: 1 2 3 4 More

Tea: 1 2 3 4 More

Soda/Other: 1 2 3 4 More

Are you sensitive to caffeine? Yes ___ No ___

Please answer the following questions:

Yes ___ No ___ Is there any history of violence, verbal or sexual abuse in your family?

Yes ___ No ___ Have you ever been physically abused?

Yes ___ No ___ Have you ever been sexually abused?

Yes ___ No ___ Have you ever experienced or witnessed a traumatic event (accidents, crime, major illness)?

I VERIFY THAT ALL INFORMATION ABOVE IS TRUE AND ACCURATE.

_____ (Signature) _____ (Date)