The Maple Counseling Center

FOR INDIVIDUAL ADULT CLIENTS

Counseling I am seeking: ☐**Individual** ☐**Couple** ☐**Group Therapy** ☐**Senior Peer**

CLIENT INFO	**EMPLOYER & STATUS**
Date of Birth: ____/_____/_____ Name: _____ Preferred Name: _____ Preferred Gender Pronouns:_____ Gender: M ☐ F ☐ Other: _____ Address: _____ City: _____ Zip: _____ Email: _____ I would like to receive email updates from TMCC ☐**Yes** ☐**No** Home #: _____ Cell #:_____ Work #:_____ Other #:_____ On what number may we leave a **confidential message**: ☐Home ❑Cell ☐Other	Company: _____ Address: _____ City: _____Zip: _____ ☐ I am self-employed ☐ I am unemployed ☐ I am retired Does an immediate relative work for the City of Beverly Hills or BHUSD? ☐**Yes** ☐**No** I am: Single ❑ Married ☐ Divorced ☐ How many people live in your household? __

How did you hear about TMCC?

Another Counseling or Mental Health Treatment Center	☐	Internet Search	☐
Referral from relative, friend or TMCC Client	☐	DCFS	☐
Therapist, Psychiatrist, Physician or Hospital Staff	❑	Other	☐

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications:

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)

50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? ☐**Yes** ☐**No**

Have you obtained services from TMCC before? ☐**Yes** ☐**No** If yes, when? _____

Are you currently affiliated with any of TMCC's volunteer or adjunctive programs? ☐**Yes** ☐**No**

Are you interested in group therapy? ☐**Yes** ☐**No** If yes, what kind?

Client Name: _____

Client ID#: _____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

(✓ your concerns)

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

Client Name: _____

Client ID#: _____

I HAVE…	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING….	**Never**	**Seldom**	**Often**	**Daily**	**For how long?**
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL AND FAMILY HISTORY

Have <u>you or a close relative</u> ever been hospitalized for a psychiatric illness? ☐**Yes** ☐**No**

Does anyone in your family have a mental illness? ☐**Yes** ☐**No**

Has anyone in your family every attempted or committed suicide? ☐**Yes** ☐**No**

Does anyone in your family have a substance abuse problem? ☐**Yes** ☐**No**

Have you ever been arrested? ☐**Yes** ☐**No**

If "yes" to any of the above, please briefly explain: _____

_____

_____

_____

_____

Client Name: _____

Client ID#: _____

1) How well you are doing on your job: **(✓)**

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
Not Working	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

2) How well you are doing in your marital/significant other relationship:

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

3) How well you are doing in your family relationships:

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

4) How well you are doing in relationships with people outside your family:

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

5) Please rate your current physical health:

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
Very Poor									Excellent

6) Please rate your general happiness and well-being:

0 □	1□	2□	3□	4□	5□	6□	7□	8□	9□
Very Poor									Excellent