JOURNEY COUNSELING WACO
209 Old Hewitt Rd., Suite C
Waco, TX 76712

File No._____ **Counselor** _____

Today's Date_____

IDENTIFICATION
Name _____ Age _____ Sex _____ Date of Birth _____
Parent or Guardian (if under 18) _____
Address _____ City_____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone_____
Email _____ SS # _____
Preferred way to contact you _____
Restrictions _____
Person to call in an emergency, relationship to you _____
Phone _____

REFERRAL
How did you learn about us?_____
If an individual, may I have your permission to thank this person for the referral? Yes _____ No _____
How did this person explain how I might help you? _____

C. MARITAL STATUS: Single [ ] Engaged [ ] Married [ ] Common-law [ ] Separated [ ]
Partner's Name _____ Age _____ Date Married _____
Divorced [ ] Number of times _____ When? _____
Widowed [ ] Date partner died _____

EMPLOYMENT
Place of employment: _____ Gross Family Income _____
School (if student) _____ Grade/ Year Level_____
Your education _____ Partner's Education _____
Partner's place of employment _____ Work Phone _____
Have you served in the military? _____ If so, what branch? _____
Has your partner served in the military? _____ What branch? _____

FAMILY OF ORIGIN
Parents Living/ Deceased (when?) Father _____Mother _____
Parents Divorced? When? _____ Remarried? When? _____

Your Place in Your Family of Origin: List your brothers and sisters including step and half-siblings, from left to right, starting with the oldest on the left, to the youngest on the right. Include yourself and circle your name. Do the same with your partner's family.
Your Family _____
Partner's Family _____

CHILDREN/ STEPCHILDREN

Name	Sex	Age	Birthdate	Grade	School

RELIGIOUS AND RACIAL/ETHNIC IDENTIFICATION

Church membership _____ Minister _____
Religious preference _____
Involvement: None _____ Some/irregular _____ Active _____
How important are spiritual concerns in your life?

_____
Ethnicity/national origin _____ Race _____
Or other similar way you identify yourself and consider important _____

MEDICAL

Primary Care Physician _____ Phone _____
Address _____ City _____ Zip _____
Relevant medical conditions (history, current condition) _____
_____
_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional) _____
_____
_____
_____
_____
_____

Allergies _____
_____
_____

Do you have a learning or reading disability, such as dyslexia? _____

Have you ever had a head injury? (falls, car accidents, etc.)? _____
Do you use alcohol? _____ If so, how much per day_____ per week _____ per month _____
Have you ever felt the need to cut down on your drinking? _____
Do you smoke? _____ If so, how much per day _____ per week _____ per month _____
Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? _____ If yes, which and when ? _____
Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____
Any family member with a drug or alcohol problem, past or present? _____

Previous Counseling/Psychotherapy History:

Date	Therapist/Agency	Reason for Termination

REASON FOR SEEKING COUNSELING TODAY: _____
_____
_____
_____

What supports do you have in your life right now?_____
Who do you feel closest to today? _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.