M. Dawn Rike, MA, LMFT, CAC II ~ Counselor

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CONFIDENTIAL INFORMATION

*The following information will remain confidential. No individuals or institution will be contacted without your prior knowledge and permission.*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ work or cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Spouse name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Children’s names and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Person to notify in case of emergency:*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Briefly describe why you are seeking counseling. How long have you had this difficulty?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*What previous help have you sought for this?*

*Psychiatrist ( ) Prayer ( ) Medical Doctor ( )*

*Psychologist ( ) Social Worker ( ) Counselor ( )*

*Chiropractor ( ) Pastor ( ) Group Therapy ( )*

*Acupuncture ( ) Naturopath ( ) Homeopath ( )*

*Hypnosis ( )*

*Other ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*What was your experience like?*

*Are you currently under medical care? No \_\_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe*

*Are you taking any prescribed medication? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe:*

*Are you currently in or plan to be involved in any civil or criminal litigation? \_\_\_\_No \_\_\_\_Yes If yes, briefly explain.*

*Page 3 Confidential Information*

*Symptoms/Areas of Struggle*

*Indicate any that apply. Place a P to indicate past and C to indicate currently.*

*\_\_\_\_Inferiority \_\_\_\_Inadequacy \_\_\_\_Worry*

*\_\_\_\_Fantasy \_\_\_\_Obsessive thoughts \_\_\_\_Pornography*

*\_\_\_\_Overeating \_\_\_\_Fear \_\_\_\_Anxiety*

*\_\_\_\_Flashbacks \_\_\_\_Anger \_\_\_\_Self-punishment*

*\_\_\_\_Insecurity \_\_\_\_Compulsive acts \_\_\_\_Masturbation*

*\_\_\_\_Frequent illness \_\_\_\_Sleep problems \_\_\_\_Seizures*

*\_\_\_\_Addictions \_\_\_\_Depression \_\_\_\_Hearing voices*

*\_\_\_\_Mood swings \_\_\_\_Guilt \_\_\_\_loneliness*

*\_\_\_\_Financial problems \_\_\_\_Suicidal thoughts \_\_\_\_Weight*

*\_\_\_\_Marital conflict \_\_\_\_Communication skills \_\_\_\_Relationships*

*\_\_\_\_Confusion \_\_\_\_Lying \_\_\_\_Abuse (any type)*

*\_\_\_\_Shame \_\_\_\_Nightmares \_\_\_\_negative thoughts*

*List any physical symptoms or health issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Date of your last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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 *Family*

*How many were in your childhood family? Who did you live with? Who were you*

*closest to?*

*Describe your parents briefly.*

*What was/is your relationship like with each of them?*

*Has anyone in your immediate or extended family ever received treatment for mental, emotional, or stress-related disorder, or for alcohol or chemical addiction? No\_\_\_ Yes\_\_\_. If yes, please indicate type of treatment and the relationship of the person to you.*

*What do you hope to gain through counseling? Do you have specific goals you wish to accomplish? You may use the back of this page if needed.*