A Safe Place to Heal
Julie Choi Kim, M.A. PCCI
Professional Clinical Counseling Registered Intern #149
Supervised by Mary Stein-Webber, MFC 35363
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PERSONAL INFORMATION (PLEASE PRINT CLEARLY)

FULL NAME _____ **DATE** _____

DATE OF BIRTH _____/_____/_____ **AGE** _____ **REFERRED BY**_____

PHONE: HOME) _____ **CELL)**_____ **WORK**)_____

Can I call you at **HOME?** YES/ NO **CELL** YES/NO **WORK** YES/NO **OTHER** YES/NO
Can I leave a message at **HOME?** YES/ NO **CELL** YES/NO **WORK** YES/NO **OTHER** YES/NO

STREET ADDRESS_____**APT/UNIT**_____

CITY_____**STATE**_____**ZIP CODE**_____

EMAIL ADDRESS_____ Can I email you? YES/NO

OCCUPATION _____ **MARITAL STATUS** _____

MEDICAL CONDITIONS: (any past of present medical problems, surgeries, accidents, illnesses, injuries?)

_____

PRIMARY CARE PHYSICIAN _____PHONE _____Last Visit _____

Other Health Care providers: _____PHONE _____ Last Visit _____

Any Prescription Medications you are currently taking?

_____

Medication	Dose/Frequency	Reason	Date Began	Prescribing Physician
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HAVE YOU BEEN IN PSYCHOTHERAPY BEFORE? If yes, when? _____

Who was your therapist? _____How long were you in treatment? _____
Reason for treatment _____
Would you say that it was successful? _____ If yes, then why? _____
_____

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Do you belong to a religious or spiritual congregation? YES/NO If yes, where?_____
Would you like spirituality to be part of your therapy? YES/NO

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to you_____ Phone _____

PARENT	**Name**	**Age**	**Occupation**
MOTHER			
FATHER			

ANY CHILDREN?
NAME/AGE_____
NAME/AGE _____
NAME/AGE _____
OTHER: _____

Past or Present Drug/Alcohol Use: (Include drug treatment/s and support groups like AA, NA, Celebrate Recovery):

Family Medical (Describe any illnesses that run in your family: history of mental illness, cancer, depression, epilepsy, suicide, etc)

_____

_____

What are your reasons for coming to counseling now?

_____

_____

Check if any apply to you:

___Abortion
___Alcohol/drug problems
___Anger issues
___Anxiety/Social anxiety
___Attachment issues
___Behavior Problems
___Communication
___Children/Parenting
___Depression
___Family Problems
___School Difficulties
____Hurts and conflicts
____Marital Issues
____Problems at work
____Personal Growth
____Self Image/Identity
____Sexual Difficulties
____Social Problems
____Stress
____Reproductive issues
____Infertility
____Grief/Loss
____Difficulty sleeping
____Blended family
____Divorce
____Suicidal Thoughts
____Eating issues
____Previous Trauma
____Faith related issues
____Current or Prev Abuse
____Other
_____
_____

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