Welcome to Spero Counseling, LLC. We ask that you take a moment to look over and fill out the following forms. This information is confidential and will assist your counselor with assessing your needs. If you need assistance filling out these forms, please ask your counselor.

Thank you.

CLIENT INFORMATION

Date of Birth: ____/_____/_____

Name: _____

Address: _____

City: _____Zip: _____

Home #_____ Cell #_____

Work #_____ Other #_____

Email _____

On what number may we leave a confidential message:

How did you hear about Spero? _____

EMERGENCY CONTACT

Notify: _____ Phone: _____

Relationship to client: _____

INSURANCE

Insurance Provider: _____

Primary Insured's Name and DOB: _____

Policy #: _____

Group #: _____

Effective Date: _____

Please contact your insurance provider to obtain your benefit information.

HEALTH AND MEDICAL

Primary Care Physician:_____

Phone:_____

Psychiatrist: _____

Phone: _____

Please list any medical problems:

_____

Please list any current medications:

_____

LIVING ARRANGEMENT/SUPPORT

Whom do you live with? (name, age, relationship)

_____

_____

What is your support system? (friends, church, groups, etc.)

_____

_____

Briefly describe your reasons for seeking counseling

_____

_____

Symptom Assessment

Please give an accurate account of your symptoms. This will help you get the most out of counseling.

Circle all that apply

Anger Anxiety Depression Grief/Loss Eating Disorder Fear/Phobia

Sexual Concerns Relationship Concerns Drugs/Alcohol Sleeping Concerns

Impulsivity Mood Swings Social Concerns Divorce Legal Concerns

Employment Concerns Education Concerns Panic Attacks

Other Concerns: _____

History of Trauma

Circle all that apply

Emotional Abuse Physical Abuse Sexual Abuse Traumatic Event

I USE THE FOLLOWING….	Seldom	Often	Daily	Never	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness?

Has a close relative ever been hospitalized for a psychiatric illness?

Does anyone in your family have a mental illness?

Has anyone in your family every attempted or committed suicide?

Does anyone in your family have a substance abuse problem?

Have you ever been arrested?

Client Signature: _____

Date