Rev. Santa CanteWi Molina-Marshall – licsw, sep

1025 Connecticut Avenue NW, Suite 1000, 10th Floor,

Washington DC, 20036

www.hpbysanta.net . hpbysanta@gmail.com . 301537-6091

Client Information

Date: _____

Name: _____

Address: _____

Telephone No.: (H/C) _____ (W) _____

Email: _____

Gender _____ Race _____ Sexual Orientation_____

Age: _____ Date of Birth _____ Place of Birth _____

Check as many as apply: Committed Relationship _____ Single _____ Divorced _____ Separated _____

Highest level of education attained: _____

Place of Employment: (Tenure & Title) _____

Do you enjoy your work? Is there anything stressful about your work? _____

_____

_____

_____

Name of child/children:	Age:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you consider yourself to be spiritual or religious, if yes, describe your faith or belief.

_____

_____

_____

Have you ever been involved in therapy or any other type of counseling program? ☐Yes ☐No

If yes, when? _____ Where? _____

Reasons: _____

Reasons for considering counseling at this time: _____

_____

_____

_____

Were you referred to this counseling office? ☐Yes ☐No If yes, by whom? _____

Are you in treatment with another counselor presently? ☐Yes ☐No

If yes, with whom? Name: _____How long? _____

Have you ever been hospitalized for any mental health reason? ☐Yes ☐No

If yes, when? _____ Where? _____

Reason: _____

Are you receiving medical treatment from a psychiatrist? ☐Yes ☐No

If yes, with whom? Name: _____ Phone _____

(Please be sure to complete and bring in in with you the consent form you will find under "helpful forms" on the website).

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

Are you presently under a physicians care for physical problems? ☐Yes ☐No

If yes, please list reasons and any medications: _____

_____

Name of family physician: _____ Phone: _____

How would you rate your sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list the specific problems you are having, if any _____-

_____

How many times per week do you exercise _____

List any difficulties you experience with your appetite or eating patterns: _____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? If yes, describe and include for how long?_____

_____

_____

Are you currently experiencing anxiety, panic attacks or have any phobias? If yes, describe and include when you began to experience this. _____

_____

_____

_____

Are you currently experiencing any chronic pain? If yes, describe_____

_____

_____

Do you struggle with any type of addiction (this includes food, alcohol, illegal drugs, prescription drugs, gambling and or sex) If so, please explain. _____

_____

_____

_____

How frequently do you use these substances or engage in addictive behaviors? _____

_____

Have you ever, or are you now being treated by any type addiction. ☐Yes ☐No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment _____

Have you experienced any form of trauma? (please include a listing of your experiences. Include, major falls, accidents, major surgeries, childhood or adult sexual abuse, neglect, physical/emotional abuse, and any other experiences you consider traumatic). Specifics are not expected. We can discuss these in person iin a regulated way.

Are you currently in a relationship? If so, for how long and how would you rate it on a scale of 1-10_____
How supportive is your partner/spouse? _____

Describe intimacy relationship history, starting with the present.

What do you consider to be some of your weaknesses?

What do you consider to be some of your strengths?

What concerns/challenges are you experiencing at this time?

What would you like to accomplish from your time in therapy?

_____

_____

_____

What resources do you have (internal and external) that help you feel a bit better?

_____

_____

_____

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle,etc).

	Please Circle	List Family Member
Alcohol/Substance Abuse	YES/NO	
Other addictions	YES/NO	
Depression	YES/NO	
Domestic Violence	YES/NO	
Eating Disorders	YES/NO	
Obesity	YES/NO	
Obsessive Compulsive Behavior	YES/NO	
Schizophrenia	YES/NO	
Suicide/Suicide Attempts	YES/NO	
Narcissistic Personality	YES/NO	

Please use this page to list any other information you deem important to share with me, that was not asked above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Person to contact in case of an emergency: _____

Phone: _____ Email:_____ Relationship to you:_____

Address: _____

_____

_____ Date:_____

(Your Signature)

Thank you for taking the time to complete this form. This will help me to serve you.