G R A Y Wellness Consulting, LLC

Personal Information: **Today's Date:** ________________________

Last Name: __________________________ First: ________________________ Middle Initial: _______________
Birth Date: ______________________________ Age: ______________
What pronouns do you use to Identify yourself? ____
Address: ____
City: _________________________ State: _________________________ Zip: ___________________________
Home Phone: ____ May I leave a message? _____
Cell Phone: ____ May I leave a message? _____

EMAIL ADDRESS: ____
VENMO: ____

How did you hear about me?
____

Single_____ Married_______ Partnered______ Divorced ______Separated_______ Engaged_______
How Long____________
Spouse/partner's name: ____
Is your spouse/partner supportive of you seeking counseling? ____

Do you have children? __________ Ages: ____
Do they live with you? ________________

Do you take care of any other individuals? ________________ Elder parent? _______________

EMERGENCY CONTACT:
Name: ___________________________________ Relationship to you: ______________________________
Address: ______________________________________ ____
Phone: _______________________________________
Are you Employed? ____
Highest Level of education: __________________________________

Do you consider yourself to be spiritual or religious? ____

Support/Social Network: Do you have people in your life that provide you with support when in need? _______
Names & phone numbers

____

____

____

____

Primary Care Physician: ____ Phone: ________________________

Address: _______________________________________ _________________________________ ____________

Physical Exam: ____within last year _____ within last 5 years _____ greater than 5 years

Overall Health: ☐ Good ☐ Fair ☐ Poor

Explain: ____

____

LIST OF MEDICATIONS:

_____________________________ __________ mg ______/day prescriber: _______________________________

_____________________________ __________ mg ______/day prescriber: _______________________________

_____________________________ __________ mg ______/day prescriber: _______________________________

SUPPLEMENTS:____

____

____

Other Physician: _______________________________________ Phone: ____________________________

Address: ___________________________________ ___________________________________ _____________

Physician:____Phone: ____________________________________

Address: ____

Medical Conditions: No Medical Conditions _________ please check

◯ Hearing problems ◯ Vision problems ◯ Asthma ◯ Birth Defects

__Seizures ___ History of Head Injury ___ Concussion ___Loss of Consciousness ___ Hypertension

___ Stroke ___ Diabetes ___Cardiac ___Thyroid ___Cancer ___ Back problems ___Fibromyalgia

__Autoimmune Disorder ____ Not Listed

Surgery: ___ none ___Recent Surgery: ________________ ___ History of Multiple Surgeries

ALLERGIES: Food, Medications (list): ____

____

____

Do you smoke Cigarettes? _____ yes _____ No How many per day? ____________

Do you drink alcohol? ______ yes _____ No

Do you take any non-prescribed (recreational) drugs? ____ Yes ____No If yes, please indicate substances used in the past or present.

Substances	Amount of Use	Frequency of use	Are you concerned about your use?
Alcohol			
Marijuana			

Cocaine/ crack/ Meth.			
Inhalants			
Stimulants			
Hallucinogens			
Heroin/Opiates			
Prescription drugs (specify):			

Do you Eat 3 balanced meals per day? _____Yes _____No

Do you exercise? _____ Yes ______ No

Are you happy with your sleep routine? _____Yes _____No

Identifiable Stress: ___ Relationships ___ Family ____ Health ____Financial ____Employment ___School Other stressors: ____

Significant Life Events (past or present):
____
____
____
____

Legal Problems: Do you currently or have you had legal problems in the past? Y N
Current P.O. ________________________________Phone: ____________________
Any restraining orders? ____________Are you court ordered to Counseling? ______ (Copy of order needed)
Have you ever set fires in the past? ____________Have you ever committed a sex crime? _______________ Have you ever been convicted of a sex crime? ______ Have you ever had thoughts, plans, or attempted to hurt/kill another person? ____________Have you ever physically hurt someone? _______________

Previous Psychological Counseling or psychiatric help? Please check all that apply.
_______ Individual Counseling ________ Group/ Couples/ Family Counseling
_________ Hospitalized for psychiatric Issues? If yes, when ___________________________
Have you had thoughts, plans or attempted to hurt/kill yourself in the past? ____________

Family History of Mental Health: Consider anyone blood related to you.
Please indicate if there is a family history of any of the following by placing a check mark:
____ Alcohol/ Substance Abuse ____ Domestic Violence ______ Sexual Abuse _____ Physical Abuse
____ Emotional Abuse _____ Suicide Attempt ______Death by Suicide _____ Eating Disorder
_____ Schizophrenia ____ Bipolar ______ Depression _____ Anxiety _____ Learning Disorders
______ ADHD/ADD _____ Dropping out of High School _____ Obesity

What do you consider your biggest strengths?

____
____

Why are you seeking counseling at this time? (**please answer**)
____
____
____

Alternative Treatments (specify which you have used in the past): ____ Chiropractor ___ Acupuncture ___ Reiki ___ Yoga ___ Meditation____ Massage Therapy ____ Cranio-Sacral Therapy ____ Aromatherapy

Name of person **FILLING OUT FORM (if different from client**) ____
Relationship to client: ____