Kissel Hill COUNSELING ASSOCIATES, LLC

Background Information

Identifying Information:

Client Name _____ Birth Date _____ Gender _____

Address _____ Race _____

Phone _____ Cell _____ Work _____

E-mail _____

Preferred form of contact _____ Where can we leave messages? _____

Marital Status _____ Name/Age of Partner _____

Occupation _____

Emergency Contact _____ Phone _____

List family members/supports *(List name, age, relationship, and place a check next to individuals residing in the home)*

_____

_____

_____

_____

_____

Medical History:

Current Medical Condition(s) _____

_____

_____

Allergies _____

_____

Prior Medical Procedures _____

_____

_____

History of Head Injury ☐ Yes ☐ No Loss of Consciousness ☐ Yes ☐ No Seizure ☐ Yes ☐ No Chronic/Acute Pain ☐ Yes ☐ No

100 Highlands Drive, Suite 103 Lititz, PA 17543
Phone (717) 625-0025 | Fax (717) 625-0009 | contact@kisselhillcounseling.com
www.kisselhillcounseling.com

Kissel Hill COUNSELING ASSOCIATES, LLC

Treatment History:

Primary Care Physician _____

Current Treatment Providers (Mental Health, Developmental Specialists, etc.)

Agency	Date Begun	Contact Person/Title
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medication(s)

Name	Dose/Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Treatment History (Include Mental Health, Psychiatric Hospitalizations, placements, developmental Specialists, etc.)

Agency	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Community Supports:

Religious Affiliation (optional) _____ Place of Worship _____

100 Highlands Drive, Suite 103 Lititz, PA 17543
Phone (717) 625-0025 | Fax (717) 625-0009 | contact@kisselhillcounseling.com
www.kisselhillcounseling.com

Kissel Hill COUNSELING ASSOCIATES, LLC

Current or Most Recent Employment Experience (Include Employer, dates, position, and reason for leaving position(s)) _____

_____

_____

_____

Past and Present Leisure Activities and Hobbies _____

_____

_____

Highest Level of Education Completed _____

Please answer the following questions…

1.	Any history of mental health concerns in your immediate or extended family?	☐ Yes ☐ No
2.	Any history of substance abuse in your immediate or extended family?	☐ Yes ☐ No
3.	Any history of legal problems in your immediate or extended family?	☐ Yes ☐ No
4.	Do you have a history of substance abuse/addiction?	☐ Yes ☐ No
5.	Do you currently struggle with substance abuse/addiction?	☐ Yes ☐ No
6.	Do you have a history of legal problems?	☐ Yes ☐ No
7.	Do you have any current legal problems?	☐ Yes ☐ No
8.	Any family history of domestic violence?	☐ Yes ☐ No
9.	Do you have a history of physical abuse?	☐ Yes ☐ No
10.	Do you have a history of sexual abuse?	☐ Yes ☐ No
11.	Do you have a history of neglect?	☐ Yes ☐ No

If you answered "yes" to any of these questions, please provide details: _____

_____

_____

_____

_____ _____ _____

Signature of Client Printed Name Date

100 Highlands Drive, Suite 103 Lititz, PA 17543
Phone (717) 625-0025 | Fax (717) 625-0009 | contact@kisselhillcounseling.com
www.kisselhillcounseling.com