ROSALIND SMITH
COUNSELING

Demographic Form

CONTACT INFORMATION

Client's Name:			
	First *Middle* *Last*		*Today's Date*
If Couple, Spouse/Partners Name:			
Address:	*First* *Middle* *Last*		
	Street Address *City* *State* *Zip*		
Home Phone:		May We Leave A Message?	☐ Yes ☐ No
Work Phone:		May We Leave A Message?	☐ Yes ☐ No
Mobile Phone:		May We Leave A Message?	☐ Yes ☐ No
Email Address:		May We Send A Message?	☐ Yes ☐ No
Emergency Contact:			
	Name/Relationship *Phone:*		
Referred by:			

PERSONAL/FAMILY HISTORY

Birth date: _____ Age: _____ Marital Status: _____

Names/Ages of Individuals that live with you

Name	Relationship	Age

Occupation (School, if child):_____

Education (Grade, if child):_____

OFFICE USE ONLY: Primary Clinician Rosalind Smith Sistrunk, MA, LPC, CDCA, BC-TMH

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MEDICAL HISTORY

Do you have any medical conditions at this time? ☐ Yes ☐ No		
If Yes, Please Explain: _____		
Primary Care Physician _____ Phone _____		
Are you currently taking any prescription medications? ☐ Yes ☐ No		
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
Name:	Dosage:-	Reason:
How often do you drink alcohol?	Type:	Times Per Week:
Do you use any other drugs?	☐ Yes ☐ No If Yes, List:	

COUNSELING/PRIOR TREATMENT HISTORY

	WHEN	REACTION TO OVERALL EXPERIENCE
Counseling/psychiatric		
Suicidal thoughts/attempts		
Drug/alcohol treatment		
Hospitalizations		
Involvement with self-help groups		

SYMPTOMS/COMPLAINTS AT THIS TIME (OR IN THE LAST 3 MONTHS)

Please check behaviors and symptoms that you experience:

☐	Aggression	☐	Fatigue	☐	Mood shifts
☐	Anger	☐	Gambling	☐	Panic attacks
☐	Anxiety	☐	Hallucinations	☐	Phobias/fears
☐	Avoiding people	☐	Heart palpitations	☐	Recurring thoughts
☐	Cyber addiction	☐	High blood pressure	☐	Sexual addictions
☐	Depression	☐	Hopelessness	☐	Sexual difficulties
☐	Disorientation	☐	Impulsivity	☐	Sick often
☐	Distractibility	☐	Irritability	☐	Sleeping problems
☐	Eating disorder	☐	Judgment errors	☐	Suicidal thoughts
☐	Elevated mood	☐	Memory problems	☐	Worrying

Other: