SOL ASSOCIATES, PLLC
INFORMATION FORM

Please provide the following information, which will remain **CONFIDENTIAL**. You may omit any question that does not apply.

PERSONAL BACKGROUND Date:_____

NAME:_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

LOCAL ADDRESS:_____

E-MAIL ADDRESS: _____

TELEPHONE:_____ OTHER PHONE: _____

WHERE IS IT OKAY TO LEAVE A MESSAGE FOR YOU? _____

EMPLOYER: _____

COUNSELING BACKGROUND

IF YOU HAVE EVER HAD PREVIOUS COUNSELING, WHERE? _____ WHEN? _____

HOW WERE YOU REFERRED? FRIEND_____ FAMILY_____ OTHER (WHO?) _____

MAY I HAVE PERMISSION TO THANK YOUR REFERROR? NO OTHER INFORMATION WILL BE SHARED: YES _____ NO _____

RATE YOUR CURRENT PHYSICAL HEALTH: POOR_____ FAIR_____ GOOD_____ EXCELLENT_____

IF YOU CURRENTLY HAVE A PHYSICIAN, WHO? _____

WHERE? _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING B.C. PILLS):

_____

HOUSEHOLD INFORMATION

FIRST NAME (OPTIONAL)	SEX	AGE	RELATION TO YOU	OCCUPATION

OTHER SIGNIFICANT PEOPLE (PLEASE SPECIFY RELATIONSHIP--spouse, partner, friend, sibling, parent, guardian, etc.)

_____

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CHECK ANY OF THE FOLLOWING ITEMS THAT CURRENTLY CONCERN YOU OR APPLY TO YOU. Check twice those items that are of most concern to you.

_____ RELATIONSHIP WITH PARTNER/SPOUSE
_____ RELATIONSHIP WITH FAMILY MEMBERS
_____ DEATH OR LOSS OF SIGNIFICANT PERSON
_____ RESTLESSNESS, RACING THOUGHTS
_____ DATING / ROMANTIC RELATIONSHIPS
_____ SPIRITUAL CONCERNS
_____ SEXUAL CONCERNS
_____ ETHNIC / RACIAL CONCERNS
_____ CONCERN ABOUT BELIEFS / VALUES
_____ SELF-ESTEEM
_____ ASSERTIVENESS, SHYNESS
_____ DECISION-MAKING ABILITIES
_____ RELATIONSHIP WITH EMPLOYER
_____ EDUCATION / EMPLOYMENT / CAREER PLANS
_____ TEST ANXIETY
_____ FINANCIAL MATTERS
_____ WORK / EMPLOYMENT
_____ RELATIONSHIP WITH FRIENDS / ROOMMATE
_____ ANGER, IRRITABILITY
_____ ANXIETY, PANIC
_____ CONCERN ABOUT ALCOHOL, DRUGS, MEDICATION
_____ PERFECTIONISM
_____ PHYSICAL STRESS (HEADACHES, UPSET STOMACH, TENSE MUSCLES)
_____ DIFFICULTY CONCENTRATING
_____ MOTIVATION, PROCRASTINATION
_____ DEPRESSION
_____ LONELINESS
_____ APPETITE CHANGES
_____ SLEEP DIFFICULTIES
_____ FOOD & BODY IMAGE CONCERNS
_____ OTHER HEALTH CONCERNS
_____ SUICIDAL THOUGHTS / ACTIONS
_____ PHYSICAL ROUGHNESS IN RELATIONSHIPS

PLEASE SUMMARIZE THE SPECIFIC CONCERN THAT BRINGS YOU HERE _____

_____

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