

**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.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.**

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

PLEASE SUMMARIZE THE SPECIFIC CONCERN THAT BRINGS YOU HERE \_\_\_\_\_

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