SPECTRUM
YOUTH & FAMILY SERVICES

Please bring completed form to initial counseling appointment.
PLEASE DO NOT SEND THIS FORM OVER EMAIL.

Counseling Admission Form

Name: _____ Date: _____ Gender: _____

Address _____
Street City Zip

Social Security #: _____ Birth Date: _____ Age: _____

Mother's Maiden Name _____

Ways to contact me: ☐ Phone ☐ Voicemail ☐ E-mail ☐ Drop-In

Phone #_____ E-mail_____ Other_____

Best Time/Day to Be Reached: _____ Okay to leave a message? ☐ YES ☐ NO

Emergency Contact: _____
Name Phone Number Relationship

Do you have Health Insurance? ☐ YES ☐ NO
If YES:

Insurance company	
Insurance ID #	
Subscriber name and date of birth	
Client's relationship to the subscriber	
Insurance co. MH/SA provider phone #	
Co-pay amount	
If no insurance, agreed fee per session	

OPTIONAL DEMOGRAPHIC QUESTIONS

RACE
☐ American Indian/Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Biracial
☐ Don't Know
☐ Other
☐ Declined to answer

ETHNICITY
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Don't know
☐ Declined to answer

PRIMARY LANGUAGE _____
PREFERRED SERVICE LANGUAGE _____
ABILITY ACCOMMODATIONS _____

Name _____ Date _____

Please briefly describe what brings you to counseling at this time.

_____
_____
_____

When did you first become concerned about the issue(s) that bring you here today?

_____
_____
_____

Previous Outpatient Therapy *(previous therapists/practitioners, dates of counseling, reason for counseling, response to counseling –was it a positive, negative, or mixed?)*

_____
_____
_____

Past Psychiatric Hospitalizations *(include mental health and/or substance use related hospitalizations; include name of hospital, dates, reason for hospitalization, and outcome of hospitalization)*

_____
_____
_____

Current Medications *(Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication)*

_____
_____
_____

Allergies *(adverse reactions to medications/food/etc.)* _____
_____

Any Relevant Medical Conditions *(diabetes, hypertension, head traumas, heart problems, asthma or other breathing problems, cancer, etc.)*

_____
_____
_____

Medical Hospitalizations/Surgeries *(include dates, complications, adverse reactions to anesthesia, outcomes, etc.)*

_____
_____
_____

Name _____ Date _____

Substance Abuse History *(Complete for all clients age 12 and over)*

SUBSTANCE	AMOUNT	FREQUENCY	DURATION	FIRST USE	LAST USE
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Family History of Mental Health or Substance Abuse/Dependence

_____
_____
_____
_____

Family Members

Name Age Gender Relationship

_____
_____
_____
_____
_____
_____

Who do you consider to be supportive people in your life? *(ex. Friends, family, co-workers, peers, church or other faith community, etc.)*

_____
_____
_____

Education History: Last grade completed; if currently a student, where? What grade/year? What is/was school like for you?

_____
_____
_____

Employment History: Are you currently working? Part-time? Full-time? Doing what? If you're not working, are you looking for work? What has your experience of work been like?

_____
_____
_____

Name _____ Date _____

What, if any, activities do you engage in for hobbies, interests, extra-curricular activities, sports, exercise, etc.?

_____
_____
_____

Do you have any spiritual, religious, or cultural beliefs or practices that you would like me to know about that might be relevant to counseling?

_____
_____
_____

What do you consider to be your strengths that would help you in being successful toward your goals in counseling?

_____
_____
_____

What might you need and prefer from your counselor or Spectrum in general in order to be successful toward your counseling goals?

_____
_____
_____