DSM _____

_____

Gwendolyn Burke, MSW, LCSW, LSCSW John Burke, LSCSW, LCSW
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PLEASE **PRINT** CLEARLY

Client's Name	circle **M/F**	Date of Birth/Age		Today's Date
Street Address	City	State	Zip Code	
Cell Phone	Home Phone	Work Phone		
Marital Status		Social Security Number		
Employer		Occupation		
Employer's Street Address	City	State	Zip Code	
Spouse/Significant Other/ Parent if minor Name:	Street Address City/State/ Zip Code (if different) SSN:		DOB:	
Home Phone	Work Phone	Cell Phone		
Employer – Spouse/Significant Other/Parent				
Employer's Street Address	City	State	Zip Code	
Previous Counseling or Therapy? **NO** **Yes – explain**				
Referred By/ Reason for coming to therapy:				
Payment Information				
Person Responsible for payment (No organizations or insurance companies)				
Should my account balance become more than 90 days past due and my account is turned over for collections, I will be responsible for the collection fees as well as any legal cost involved in its collection.				
Do you wish your insurance filed? **NO** **YES**				
Insurance Company	Street Address	City	State	Zip Code
Name of Insured	Social Security Number of Insured			
Member ID#	Group #			
I understand my general payment responsibilities are outlined above and I authorize payment of benefits to Gwendolyn Burke/Burke Counseling & Consulting, Inc. and the release of any information necessary to process the claims.				
Signature_____ Date_____				

Emergency Contact Person (REQUIRED):

Name:_____Address_____

Best way to contact:_____

Others living in the home:

Name(s)	Date of Birth	School/Employer

Have you ever felt like you should cut down on your drug or alcohol use? Yes No
Has a friend or relative expressed concerns about your use? Yes No
Have you ever felt guilty about your drinking or drug use? Yes No
Are you a recovering alcoholic or a recovering drug addict? Yes No
Is there a history of problems with drugs or alcohol use in your family? Yes No

How was your job performance rated on your last review? _____
_____
_____

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking:

Check substance you use in any amount at all: **How much do you use per:**

Substance	**Age of first use**	**Weekday**	**Weekend**	**Month**	**Last Used**
Beer					
Liquor					
Marijuana					
Cocaine/Crack					
Methamphetamine/Crystal					
Heroin					
Barbiturates (downers)					
PCP,LSD (hallucinogens)					
Tobacco (in any form)					
Other					

History of treatment for emotional problems and family history:

Outpatient treatment Yes No Did it help? Yes No
Therapist's name _____ Dates of treatment _____

Inpatient treatment No Yes
Where _____
When _____
Length of Stay _____

Is there a family history of emotional problems? Yes No
Who _____
Relationship to you _____

CLIENT REPORT OF PROBLEM

Name _____ Today's Date_____

Briefly describe your reason(s) for seeking help: _____

How long have you had the problem(s)? _____

Why did you decide to seek help now? _____

What other ways have you tried to deal with this problem? _____

Check all that apply to you:

	Thoughts of suicide		Thoughts of harming others		Phobia
	Trouble getting to sleep		History of attempts to kill yourself		Panic attacks
	Waking during the night		Cutting or otherwise hurting self		Excessive guilt
	Financial Problems		Feelings of hopelessness		Forgetfulness
	Loss of Appetite		Inability to make decisions		Mood swings
	Hearing Voices		Large weight gain or loss		Family Problems
	Problems at work		Seeing things others don't		Violence toward others
	Trouble Concentrating		History of physical abuse		Tingling and Numbness
	Racing Thoughts		*History of sexual abuse*		*Depressed Mood*
	Legal Problems				

Are you currently having thoughts of suicide? No Yes – what is your plan - explain

Are you currently having thoughts of homicide? No Yes – Who would you harm?
What is your plan – explain _____

HEALTH INFORMATION

	CLIENT	SPOUSE	PARENTS (if minor client)
Present Health:			
Medical concerns:			

Health Status

List any medical problems or physical problems and when they were diagnosed:

1. _____
2. _____
3. _____
4. _____

List any major surgeries (where you were put to sleep) you have had to date:

1. _____
2. _____
3. _____
4. _____

List any serious illness or injuries especially anything involving the head:

1. _____
2. _____
3. _____
4. _____

List any allergies to food or drugs:

1. _____
2. _____
3. _____
4. _____

Medical Information

Primary Care Physician:			Date of last visit:
Address	City	State Zip Code	Phone#
Psychiatrist:			Date of last visit:
Address	City	State Zip Code	Phone #
May we contact your doctor(s)? No Yes			
Signature_____			