5. HCC Background INFO

Background Information

Welcome to the Healing Counseling Center of Mckinney! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you after he/she has reviewed the form.

Full Name:

Date of Birth : MM/DD/YYYY:

Gender Identification::

Date of first Visit::

Occupation /Time at current Job:

Highest Level of Education::

Ethnicity::

Primary Language::

CONTACT INFORMATION:
We will leave a general voicemail message at any phone number listed below. If you do not wish us to leave a message, please do not provide that phone number

Cell Phone::

Home Phone::

Work Phone::

Preferred email Address::

Mailing Address::

May we contact you at the email address above::

Emergency Contact - Name and Phone:

Emergency Contact / EMAIL:

Who referred you to our Center? (Please be specific)::

May we contact this referral source to thank them for the referral::

CURRENT CONCERNS: General reason(s) for seeking counseling services at this time::

Please mark each item you see as an ongoing struggle in your life that you would like to work on in counseling.

Issues Related to Abuse

- ☐ Current or past physical abuse
- ☐ Current or past sexual abuse
- ☐ Current or past emotional abuse
- ☐ Current or past neglect
- ☐ History of abandonment/rejection
- ☐ Suspected sexual abuse
- ☐ History of family domestic violence

Mood-Related Concerns

- ☐ Disturbing Memories
- ☐ Difficulty going to sleep/staying asleep
- ☐ Nightmares/Night Terrors
- ☐ Suicidal Thinking or talking
- ☐ Suicidal attempting
- ☐ Sadness/Depression

- ☐ Feelings of guilt and shame
- ☐ Excessive Worry and Fear
- ☐ Irritability
- ☐ Hallucinations
- ☐ Poor Concentration
- ☐ Low Energy

Behavioral/Conduct Issues

- ☐ Aggression towards others
- ☐ Excessive Drug use/Alcohol use
- ☐ Hyperactivity/Impulsivity
- ☐ Excessive Computer use
- ☐ Behavioral Issues at school / work
- ☐ Panic Attacks
- ☐ Time Management Concerns
- ☐ Betraying Reationships
- ☐ Engaging in High risk taking behaviors
- ☐ Fire-Setting
- ☐ Low Self Esteem
- ☐ Obsessive Compulsive Behaviors
- ☐ Phobias

Phobias : Please specify:

Career/ Academic Issues

- ☐ Colleague/Cohort problems
- ☐ Harassment Issues
- ☐ General work performance issues
- ☐ Failing grades
- ☐ Chronic Stress
- ☐ Career dissatisfaction

- ☐ General problems at work/school
- ☐ Financial Concerns

Family Relationship Concerns

- ☐ Difficulty adjusting to family changes
- ☐ Parenting/Discipline concerns
- ☐ Parent-child relationship concerns
- ☐ Divorce
- ☐ Seperation
- ☐ Religious/Spiritual concerns
- ☐ Estranged Relationships
- ☐ Constant Fighting

Other Behavioral Concerns

- ☐ Sexual Identity questioning
- ☐ Sexual issues in general
- ☐ Appetite/ Eating Concerns
- ☐ Poor Body Image
- ☐ Sleep Problems
- ☐ Lying
- ☐ Anxiety
- ☐ Inattentiveness
- ☐ Lonely
- ☐ Bored with Life
- ☐ Isolation / social withdrawal
- ☐ Fear of Dying
- ☐ Feeling that you are not real
- ☐ Feeling that things around you are not real

Other Unusual Behaviors : (Please Specify):

When did you first become concerned about the main/most significant issue?:

Are you currently experiencing suicidal thoughts?_______________ If so please elaborate::

Are you currently experiencing any homicidal thoughts?:

If so please elaborate:Other treatment you have received to address any of the concerns indicated above::

Are you currently in counseling elsewhere?:

(If yes, we require written confirmation of the counselor’s consent for treatment by the center)

Are other family member recieving services at this clinic? If Yes, please state Names and Dates of service::

Are you seeking services because you are a victim of a crime?:

Are you currently on probation?:

Have you ever been dishonorably discharged from the military?:

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)?:

(If yes, we will need your permission in order to communicate with that individual or agency. We reserve the right to postpone
services until prior treatment providers are contacted.)

Previous Mental Health Professional/Agency: Name , Address , Phone, Date of Service:

Check the following items for a diagnosis or medication you are now receiving or have received:

- ☐ Depression
- ☐ ADHD
- ☐ ADD
- ☐ Learning Disability
- ☐ Anxiety/Nervousness
- ☐ Panic Attack
- ☐ Personality Disorders
- ☐ BPD

- [ ] Manic-Depression (Bipolar)
- [ ] Schizophrenia
- [ ] Mood/Anger
- [ ] Tics
- [ ] Insomnia/ Sleeplessness
- [ ] Obsessive /Compulsive
- [ ] Addictions
- [ ] Convulsions

For each diagnosis above please List: Date of Diagnosis /Medication given and Doseage/ Currently taking or Past:

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If you have been diagnosed, who gave you the diagnosis? Please list Name and Title ::

Any Other medications you are currently taking::

History of family violence::

History of criminal activity::

History of Protective orders::

If yes , Please Explain ::

Family History

Were you adopted? If yes, at what age?:

Briefly describe your relationship with your mother?:

Briefly descrie your relationship with your father?:

Siblings and their ages::

Are your parents married or divorced::

Who raised you? Where did you grow up?:

Family member mental conditions::

Are you currently married? If yes please describe date of marriage and relationship with partner::

Are you divorced? If yes, specify date::

Prior marriages? If yes, how many?:

Do you have any children? If yes, how many with ages and describe relationship::

Are you a member of a religious or spiritual group?:

DRUG/ALCOHOL USE:

Please specify any substances used currently or in the past::

Have you ever been treated for drug or alcohol abuse? If yes, please specify dates and type of treatment::

*** is there anything else you would like your counselor to know?:

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.
Client/Guardian

Client/Guardian - Date:

CONTACT INFORMATION FOR TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL:
1801 Congress Ave., ste. 7300, Austin, Texas 78701 Phone:(512) 305-7700 Fax: (800) 821-3205
investigations/complaints 24-hour toll-free system: (800) 821-3205

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