CAREER CENTRAL

934 N Magnolia Ave Suite 212
Orlando, FL 32803
(407) 951-0505
www.careercentralcfl.com

GENERAL PATIENT INFORMATION

Date___________ **How did you hear about us?**______________________________

Full Name: □ Mr. □ Mrs. □ Ms. □ Dr. ____

Nick Name:_____________________ **Preferred Name:**________________________

Age:______ **Date of Birth:**________________ **Gender:** □ Female □ Male □ Nonbinary

CONTACT INFORMATION

Street Address:____

City:_________________________ **State:**_________ **Zip Code:**_____________

Mailing Address (if different from above):_________________________________

City:_________________________ **State:**_________ **Zip Code:**_____________

May we send mail to your home or mailing address? □ Yes □ No

Home Phone:_____________________________ **May we leave a message?**______

Cell Phone:_______________________________ **May we leave a message?**______

Work Phone:_____________________________ **May we leave a message?**______

Email:_____________________________________ **May we send an email?**______

I would like to be added to Career Central's Newsletter to receive free articles, tips and resources **□ Yes □ No**

EMERGENCY CONTACT

Name:_______________________________ **Relationship:**_____________________

Home Phone:_______________________ **Cell Phone:**________________________

EMPLOYMENT INFORMATION

Employer:________________________________ **Length of Employment:**________

Occupation:_______________________ **Average Hours Worked Per Week:**_______

Average Annual Salary: □ $0 to $10,000 □ $10,001 to $20,000 □ $20,001 to $40,000

□ $40,001 to $50,000 □ $50,001 to $60,000 □ $60,001 to $80,000

□ $80,001 to $100,000 □ More than $100,000

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CULTURAL BACKGROUND

Race: □ White □ Black □ Hispanic □ Asian □ Other:______________________________

How much do you identify with your ethnic heritage?

□ Not at all □ A little □ Somewhat □ Moderately □ Strongly

Does your family speak a language other than English at home?

□ Not at all □ A little □ Somewhat □ Moderately □ Strongly

If yes, what language?____

Were you born in the United States? □ Yes □ No □ Unsure _____________________

Were your biological parents born in the U.S.? □ Yes □ No □ Unsure_____________

RELATIONAL INFORMATION

Relationship Status: □ Single □ Dating □ Engaged □ Married □ Divorced □ Widowed

Are you content with your current relationship status? □ Yes □ No

If no, please briefly explain:____

If you are married, how long?__________________________

Number of previous marriages for you:_______________ **Your partner:**_________

If separated or divorced, how long?____________ **If widowed, how long?**________

Partner's Name:____ **Age:**_________

How long have you known your partner?____________________________________

With Whom Do You Currently Live (*Check All that Apply*):

□ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s) □ Significant Other □ Roommate

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CHILDREN

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Biological, Adopted, Step-Child)*	Living With You?	Describe Child

Have you ever placed a child for adoption? □ Yes □ No **If Yes, when?**__________

Ever had a miscarriage or medical abortion? □ Yes □ No **If Yes, when?**__________

FAMILY OF ORIGIN

Please list Mother, Father, Brothers, Sisters, Step Family, and any other Family Members who affected you either positively or negatively

Name	Sex	Current Age or Year of Death	Relationship to You	Occupation	Describe Family Member

Please check any past, present or impending issues/problems in your family

- □ Deaths
- □ Financial crisis/unemployment
- □ Debilitating injuries/disabilities
- □ Eating Disorders
- □ Marital affairs/infidelity
- □ Physical Abuse
- □ Frequent relocations
- □ Attempted/completed suicide
- □ Serious chronic illness
- □ Divorce
- □ Legal Problems
- □ Alcohol/Drug Abuse
- □ Psychiatric Disorders

Please specify family member(s), problem/issue & approximate year of occurrence:______________________________

____

____

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FAMILY CONTINUED

In general, how happy or adjusted were you growing up?

□ Poor □ Unsatisfactory □ Average □ Substantial □ Completely

How much is your immediate family a source of support for you?

□ None □ Little □ Somewhat □ Substantial □ Always

How much conflict in value do you experience with your parents?

□ None □ Little □ Somewhat □ Substantial □ Always

Who in your family do you currently feel closet to?___________________________

Most distant from?_________________ **In most conflict with?**_________________

MEDICAL & SOCIAL INFORMATION

How is your current physical health? □ Poor □ Fair □ Satisfactory □ Good □ Excellent

Primary Physician: _______________________________ **Phone:** _______________

Address:___________________________________ **City:**____________ **Zip:**_______

Are you currently receiving medical treatment? □ Yes □ No **If Yes, please specify:**

____

____

List any Injuries, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (you may use the back if necessary) ________________

____

____

Please list all Medications that you are currently taking:______________________

____

____

Are you taking these medications according to your doctor's recommendations?
□ Yes □ No **If No, please explain:**____

Are you having any problems with your sleep habits? □ Yes □ No

If Yes, please check all that apply: □ Too Much Sleep □ Too Little Sleep
□ Poor Quality Sleep □ Disturbing Dreams □ Other _____________________________

How often do you exercise per week? _________________ **How long?**__________

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MEDICAL & SOCIAL INFORMATION CONTINUED

	Past	Now		Past	Now		Past	Now
Headaches			Dizziness			Stomach Trouble		
Visual Trouble			Sleep Trouble			Trouble Relaxing		
Weakness			Tension			Rapid Heart Rate		
Difficulty Breathing			Intestinal Trouble			Hearing Noise		
Change in Appetite			Fatigue			Pain		
Hearing Voices			Seeing Things			Other		

	Past	Now		Past	Now		Past	Now
Stress			Nervousness			Anxiety		
Panic			Unhappiness			Depression		
Guilt			Apathy			Terminal Illness		
Recent Death			Grief			Hopelessness		
Feelings of inferiority			Defective Feelings			Loneliness		
Shyness			Fears			Friends		
Marriage			Communication			Physical Abuse		
Emotional Abuse			Verbal Abuse			Sexual Abuse		
Temper			Anger			Aggressiveness		
Bad Dreams			Concentration			Racing Thoughts		
Unwanted Thoughts			Memory			Loss of Control		
Impulsive Behavior			Self-Control			Compulsivity		
Sexual Problems			Pregnancy			Abortion		
Legal Matters			Trauma			Eating Problems		
Drug Use			Alcohol Use			Trouble with Job		
Career Choices			Ambition			Making Decisions		
Children			Being a Parent			Finances		
Recent Loss			Disaster			Smoking Cigarettes		

LEVEL OF DISTRESS

Indicate how distressed you are by circling a number on the scale below *(1 = Very Little Distress; 10 = Extreme Distress)*

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1 2 3 4 5 6 7 8 9 10

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PREVIOUS COUNSELING

Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? □ Yes □ No

List any previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care that you have received (you may use the back if necessary):

Therapist:______________________________________ Location:___________________

Dates:__________________ Reason:____

Therapist:______________________________________ Location:___________________

Dates:__________________ Reason:____

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have any of your friends or family attempted or committed suicide? □ Yes □ No

If Yes, please list Who and When:____

Have you ever intentionally harmed yourself? □ Yes □ No

If yes, how often? □ Daily □ Weekly □ Monthly □ Rarely

Nature of harm:____

Have you ever intentionally hurt someone? □ Yes □ No

Nature of harm:____

Have you ever had any traumatic experiences? □ Yes □ No **When?**____________

Nature of experience(s):____

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching? □ Frequently □ A Few Times □ Once □ Never □ Unsure

***** Form continues on next page *****

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PRESENTING ISSUES AND GOALS

Please describe why you are seeking counseling *(i.e. what problems or issues are you experiencing)*:

Why have you decided to come to counseling *now*?

What do you hope to gain or change in counseling?

How long do you believe counseling should last?

TERMS OF SERVICE

I hereby give the Career Central Corp counselor(s) on staff permission to provide counseling services for the patient mentioned above.

Signature:______________________________ **Date:**______________

Printed Name:______________________________

Relationship to Patient:______________________________