KINGA
KONDOR-HINE
TRAUMA THERAPIST

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PLEASE COMPLETE THE FOLLOWING WITH AS MUCH DETAIL AS POSSIBLE.

DATE _____

LAST NAME _____ FIRST NAME _____

ADDRESS _____ EMAIL _____

DOB _____ GENDER ○ MALE ○ FEMALE ○ OTHER

REFERRED BY ○ FRIEND ○ RADIO ○ SOCIAL MEDIA ○ FORMER CLIENT ○ DOCTOR ○ OTHER _____

WHAT CONCERNS BRING YOU TO COUNSELING? IS THERE A SPECIFIC REASON/PARTICULAR EVENT? BE SPECIFIC.

WHAT ARE YOUR GOALS FOR COUNSELING? WHAT WILL BE DIFFERENT AFTER OUR WORK TOGETHER?

ARE THERE OTHER FAMILY MEMBERS IN YOUR HOUSEHOLD? PLEASE LIST NAME/AGE/RELATIONSHIP

WHAT IS YOUR LEVEL OF EDUCATION? HIGHEST GRADE/TYPE OF DEGREE?

WHAT IS YOUR CURRENT OCCUPATION? WHAT DO YOU DO? HOW LONG HAVE YOU BEEN DOING IT?

ARE YOU A VETERAN OF THE USM? ○YES ○ NO IF YES, ○ARMY ○NAVY ○MARINES ○ AIR FORCE ○COST GUARD

DO YOU HAVE A FAMILY MEMBER IN THE U.S. MILITARY? ○YES ○ NO

HAVE YOU SEEN A MENTAL HEALTH PROFESSIONAL BEFORE? ○YES ○NO

PREVIOUS COUNSELING, EAP, OR CHEMICAL DEPENDENCY SERVICES:

DATE(S)	FACILITY/COUNSELOR'S NAME	REASON YOU WERE SEEN

DO YOU HAVE SUICIDAL THOUGHTS? ◯ YES ◯ NO HAVE YOU EVER ATTEMPTED SUICIDE? ◯ YES ◯ NO

PAST HOSPITALIZATIONS: MEDICAL, PSYCHIATRIC, CHEMICAL DEPENDENCY

DATE(S)	HOSPITAL	REASON

IS THERE A HISTORY OF MENTAL ILLNESS IN YOUR FAMILY? PLEASE DESCRIBE.

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED **IN THE PAST 6 MONTHS**

- ❍ INCREASED APPETITE
- ❍ TROUBLE CONCENTRATING
- ❍ EXCESSIVE SLEEP
- ❍ ISOLATION FROM OTHERS
- ❍ LOW SELF-ESTEEM
- ❍ TEARFUL OR CRYING SPELLS
- ❍ FEAR
- ❍ PANIC
- ❍ DECREASED APPETITE
- ❍ DIFFICULTU SLEEPING
- ❍ LOW MOTIVATION
- ❍ FATIGUE/LOW ENERGY
- ❍ DEPRESSED MOOD
- ❍ ANXIETY
- ❍ HOPELESSNESS
- ❍ OTHER _____

HEALTH + MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ PHONE _____ FAX _____

GENERAL HEALTH ○ EXCELLENT ○ GOOD ○ FAIR ○ POOR

CURRENT PHYSICAL CONCERNS

PRESCRIBED MEDICATIONS:

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____

DO YOU USE RECREATIONAL DRUGS YES ❍ NO ❍

If yes, how much and how often? _____

DO YOU DRINK ALCOHOL YES ❍ NO ❍

If yes, how much and how often? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ❍ HEADACHE
- ❍ GASTRITIS OR ESOPHAGITIS
- ❍ HEAD INJURY
- ❍ IRRITABLE BOWELS
- ❍ LOSS OF CONSCIOUSNESS
- ❍ BONE OR JOINT PROBLEMS
- ❍ KIDNEY-RELATED ISSUES
- ❍ DIZZINESS
- ❍ HEART VALVE PROBLEMS
- ❍ FIBROMYALGIA
- ❍ SHORTNESS OF BREATH
- ❍ HEPATITIS
- ❍ ARTHRITIS
- ❍ HIGH BLOOD PRESSURE
- ❍ HORMONE-RELATED PROBLEMS
- ❍ ANGINA OR CHEST PAIN
- ❍ CHRONIC PAIN
- ❍ HEART ATTACK
- ❍ SEIZURES
- ❍ CHRONIC FATIGUE
- ❍ FAINTNESS
- ❍ URINARY TRACT PROBLEMS
- ❍ NUMBNESS + TINGLING
- ❍ DIABETES
- ❍ ASTHMA
- ❍ THYROID ISSUES