Varady Counseling Services, LLC
LICENSED PROFESSIONAL COUNSELOR

Confidential Information Form

PERSONAL INFORMATION

Name _____ Birth date _____
Gender: M / F

Address_____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Is it okay to leave a voice message at the # above? Y / N

Is it ok to communicate via the e-mail address listed above? Y / N

Your occupation _____ Your Education level_____
Employer _____ Work Phone _____
Address_____
Length of Employment at above _____

Spouse's name_____ Birthdate_____

Spouse's Occupation_____
Spouse's employer_____ Work Phone_____

Please list additional family members living with you:

_____
_____
_____
_____

Person to contact in emergency _____ Phone _____
Address _____Relationship to you
_____

Referred by: (circle one) pastor, attorney, physician, relative, former/other client, friend, online, other

Name of referring person / party
_____

PROBLEM INFORMATION

Briefly describe your chief concern_____
_____
_____

Briefly describe the history and development of your concern from onset to present
_____
_____
_____

Current stressors (describe how the following areas are stressful:)

Marriage and home_____

Children/parents _____

Work/school _____

Financial _____

Social_____

Spiritual _____

Sexual _____

Other _____

Major present stress _____

Rate how strongly you want to change your present problem on the scale below:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire change)

Identify any specific concerns or anxieties you have about counseling _____
_____
_____

What are your goals for counseling (be as specific as you can)_____
_____
_____

Previous counseling? Y / N When? _____ By Whom?_____

How helpful was previous counseling? _____
_____

HEALTH

Present health (circle one): Excellent Good Fair Poor

What serious illnesses have you had and when?_____
_____

Hospitalizations (reason/diagnosis/dates) _____
_____

Medications currently taken, their purpose, & dosage (include non-prescription medications, sleeping pills, diet pills, etc.)
_____

Current symptoms (Please circle all that apply to you):

headaches	dizziness	fainting spells	nervousness	stomach trouble
no appetite	bowel disturbances	recent weight gain	recent weight loss	fatigue
sleep disturbances	racing thoughts	nightmares	alcoholism	drugs
can't make decisions	don't like weekends and vacations	suicidal thoughts / feelings	recurrent troubling thoughts	unable to have a good time
feel lonely	shy with people	can't make friends	unable to relax	over-ambitious
take sedatives	persistent fears	financial concerns	sexual concerns	feel depressed
bad home conditions	inferiority feelings			

(other)_____
_____

List any current or past history of alcoholism or drug addiction for you or any family member_____
_____

List any current or past history of nervous or emotional disorder for you or any family member_____
_____

Date_____

Signed_____