WHOLE HEALTH PLUS Counseling Application	**Internal Use Only** Today's Date & Time: _____ DSM V, Axis I Code: _____ Circle Type: I, C, F, G or Assessment Only

FULL Name: _____ D.O.B. _____
Address: _____
Preferred phone #: (*indicate if NOT okay to leave messages*): _____
E-mail: _____ Employed? Y/N?
Emergency contact (*name, relationship & phone #):* _____
Check if __ Single __ Married __ In relationship __ Separated __ Divorced __Widowed __Engaged __Children or Pets? If yes, list names and what ages?
_____
_____
Indicate all current physical health problems or medical diagnosis? __aches/tension __neck/back problems, __organ or gland dysfunction (i.e. liver, bladder, lung, skin, reproductive, etc.) __allergies __high blood pressure __easily sick, __other issues:
_____
Please list current medications or supplements and what they are for:
_____
_____
_____
Who prescribes your medication or provides any additional treatment or help?
_____
Any past and/or present legal, criminal or abuse involvement? Y/N?
Has anyone tried to hit or threaten you or make you feel unsafe? Y/N?
Do you feel uncomfortable, unsafe or in danger by anyone currently? Y/N?
If yes, do you have a safety/crisis plan or a trusted friend to stay with? Y/N?
Any past or recent suicidal or homicidal thoughts, attempts or plans? If yes, how many times, when & how? _____
Any self-injurious behaviors (i.e. cutting, bulimia) Y/N? or addictions (i.e. alcohol/drug abuse, pornography, gaming, phone, food)? _____
SELF PAY OR CO-PAY due at time of visit. $75/hour $110/90 minutes
Insured? Y/N? If yes, do they offer Mental Health Coverage? Y/N?
Indicate if someone other than you are responsible for payment and please sign a release and list name, e-mail and phone number of this third party: Y/N?