The Breakaway
Demographic Form

CONTACT INFORMATION

Client's Name:		
	First *Middle* *Last*	*Today's Date*
If Couple, Spouse/Partners Name:		
	First *Middle* *Last*	
Address:		
	Street Address *City* *State* *Zip*	

Home Phone:		May We Leave A Message?	☐ Yes ☐ No
Work Phone:		May We Leave A Message?	☐ Yes ☐ No
Mobile Phone:		May We Leave A Message?	☐ Yes ☐ No
Email Address:		May We Send A Message?	☐ Yes ☐ No

Emergency Contact:		
	Name/Relationship	*Phone:*
Referred by:		

PERSONAL/FAMILY HISTORY

Birth date: _________________ Age: __________ Marital Status: _________________________

Names/Ages of Individuals that live with you

Name	Relationship	Age

Occupation (School, if child):____

Education (Grade, if child):____

OFFICE USE ONLY: Primary Clinician Rosalind Sistrunk, MA, LPC

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MEDICAL HISTORY		
Do you have any medical conditions at this time?		☐ Yes ☐ No
If Yes, Please Explain: ___		
Primary Care Physician ___ Phone ___		
Are you currently taking any prescription medications?		☐ Yes ☐ No
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
Name:	Dosage:-	Reason:
How often do you drink alcohol?	Type:	Times Per Week:
Do you use any other drugs?	☐ Yes ☐ No If Yes, List:	

COUNSELING/PRIOR TREATMENT HISTORY		
	WHEN	REACTION TO OVERALL EXPERIENCE
Counseling/psychiatric		
Suicidal thoughts/attempts		
Drug/alcohol treatment		
Hospitalizations		
Involvement with self-help groups		

SYMPTOMS/COMPLAINTS AT THIS TIME (OR IN THE LAST 3 MONTHS)

Please check behaviors and symptoms that you experience:

	Aggression		Fatigue		Mood shifts
	Anger		Gambling		Panic attacks
	Anxiety		Hallucinations		Phobias/fears
	Avoiding people		Heart palpitations		Recurring thoughts
	Cyber addiction		High blood pressure		Sexual addictions
	Depression		Hopelessness		Sexual difficulties
	Disorientation		Impulsivity		Sick often
	Distractibility		Irritability		Sleeping problems
	Eating disorder		Judgment errors		Suicidal thoughts
	Elevated mood		Memory problems		Worrying

Other: