**Shelly Killingsworth, LPC, Child & Family Counselor**

**118 Exchange PL., Lafayette, La 70503**

**Phone: 337-242-7307 ; Fax: 337-534-8057** **worthcounselinggroup @gmail.com**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

(Street)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(City)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(State)\_\_\_\_\_\_\_\_(Zip)\_\_\_\_\_\_\_\_\_

*List only numbers you give consent for me to contact you or leave a message.*

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Concerns: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
|  □ Marriage/Partner  | □ Financial Situation | □ Sleeping Habits □ Addictions |
| **□** ​Family  | □ Legal Situation | □ Suicidal thoughts □ Anxiety  |
| □ Job/School  | □ Mood | □ Health □ Spirituality |
| □ Friendships | □ Eating Habits | □ Ability to Control Temper  |

□ Other

If checked other, please explain.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   | None  | Minimal  | Mild  | Moderate  | Severe  | profound  |
| Marriage/family  | 0  | 1  | 2  | 3  | 4  | 5  |
| Work/school  | 0  | 1  | 2  | 3  | 4  | 5  |
| Social  | 0  | 1  | 2  | 3  | 4  | 5  |
| Daily Life  | 0  | 1  | 2  | 3  | 4  | 5  |

**Current Level of Functioning** (Please rate level of impairment in each area):​

**What do you hope to achieve in counseling?**

**Are you currently taking any psychotropic drugs? (Anything to stabilize mood or behavior)\_\_\_\_\_ YES \_\_\_\_\_ NO (If yes, please explain and provide name of prescribing physician.)**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Check all that apply.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| € | Headaches  | € | Feeling shy around others  |  | € | Drug use  |
| € | Sleep problems  | € | Stomach problems  |  | € | Not confident  |
| € | Memory problems  | € | Trouble concentrating  |  | € | Concerned about eating habits  |
| € | Heart palpitations  | € | Grief or loss  |  | € | Alcohol use  |
| € | Depression  | € | Feelings of hopelessness  |  | € | Nightmares  |
| € | Feeling tense or nervous  | € | Disturbing thoughts  |  | € | Feelings of worthlessness  |
| € | Academic concerns  | € | Mood swings  |  | € | Hallucinations  |
| € | Worries about money  | € | Suicidal thoughts  |  | € | Recurring thoughts  |
| € | Having a lack of friends  | € | Sexual identity concerns  |  | € | Trembling  |
| € | Feelings of panic , fear, phobias  | € | Memory problems  |  | € | Anger  |
| € | Feeling sad or depressed  | € | Abusing others  |  | € | Chronic pain  |
| € | Feeling restless  | € | Problems at home  |  | € | Dizziness  |
| € | Low self-esteem  | € | Antisocial or illegal behavior  |  | € | Feeling a need to be on the go  |
| € | Aggression  | € | Abused by others  |  | € | Concerned about family members  |
| € | Chest pain  | € | Disorganized thoughts  |  | € | Sick often  |
| € | Sexual concerns  | € | Impulsive  |  | € | Relationship Problems  |
| € | Ideas of harming others  | € | Blaming or criticizing self  |  | € | Poor Judgment  |
| € | Feeling tired  | € | Anxiety  |  | € | Irritability  |
| € | Isolating self  | € | Distractibility   |   |  |  |

Reason for Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Bill:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Method: Private Pay (See Declaration of Practices & Procedures)

I understand that all services are provided on a cash/check/credit card basis payable immediately upon delivery unless otherwise arranged.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_