**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_