STEPPING STONES COUNSELING CENTER, LLC

Name:_____ Date of Birth:_____

Phone Contact Home:_____ Work:_____ Cell:_____

At which number(s) may we leave a message (Circle): Home Work Cell

Mailing Address:_____

City/State/Zip:_____

Spouse/Parent(s):_____ Age:_____

Children/Siblings(s):_____ Age:_____
_____ _____
_____ _____

Employer:_____

How did you hear about us?_____

What do you hope to accomplish in Counseling?_____

_____

Church Affiliation:_____ Doctor:_____

Previous Counselor:_____

Current Medical Conditions:_____

Medications:_____

Describe any traumatic events you have experienced in the past (accidents, abuse, neglect, fear, violence, etc.) _____

Describe any legal problems you are facing at this time: _____

_____

How often do you exercise?_____ Average hours of sleep/night?_____
Hours you work each day?_____ Caffeine Intake (amount/day):_____
Alcohol use (type/amount):_____ Drug use (type/amount): _____