

Kathy Radina, M. Ed.
Licensed Professional Counselor
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480-488-6096

Name _____ Age _____ Date of Birth _____

Address _____ City _____ Zip _____

Occupation _____ Employer _____

Best numbers where you can be reached? Please indicate cell, work or home and at which numbers I may leave a message.

Partner Name _____ Age _____ Date of Birth _____

Occupation _____ Employer _____ Phone _____

Children Names and Ages _____

Current Living Situation: Alone, With Partner, With Parents, Roommate, Other _____ Relationship Status (M, W, D) _____

Referred by _____ Person to call in case of emergency _____

Relationship _____ Phone _____

Are you currently under the care of a Physician, Psychologist or Psychiatrist? _____ Name _____

Address _____ Phone _____

Reason for care? _____

Have you been hospitalized for any reason over the past five years? _____ Reason? _____

Please list any medications, drugs, or over the counter remedies you take, and for what. _____

Have you had counseling in the past? _____ With whom? _____

Diagnosis or reason for therapy? _____

What did you like most about it? _____

Least? _____

Are you currently in an emotional crisis? _____ If yes, please explain _____

Please list any history of drug or alcohol abuse. _____

Please indicate any relevant history of loss i.e.; death, divorce, disability, other _____

Please indicate any history of trauma or abuse. _____

If you are experiencing the following symptoms, please indicate if they are MILD, MODERATE or SEVERE;

Depression _____ Anxiety _____ Panic _____ Anger _____ Sleep Dysfunction _____

Eating Dysfunction _____ Relationship problems _____ Work problems _____ Other _____