



**Child & Family Services of Saginaw County**  
**2806 Davenport, Saginaw MI**  
**989-790-7500**

Please complete form with information about **YOURSELF.**

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Gender Male Female  
(Circle One)

Who to contact in emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I am seeking counseling for the following reason(s): \_\_\_\_\_

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Names of individuals to be involved in counseling:

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Method of Payment: Private Pay \_\_\_\_\_ Insurance \_\_\_\_\_ Other \_\_\_\_\_

**EMPLOYMENT HISTORY**

Previous Employment	Length of Stay	Reason for Leaving

Current Employer \_\_\_\_\_ Date Began \_\_\_\_\_

Job Title/function \_\_\_\_\_ Schedule \_\_\_\_\_

Stresses at Work \_\_\_\_\_

Do you like your job? \_\_\_\_\_

**EDUCATIONAL HISTORY**

Highest grade completed \_\_\_\_\_ GED \_\_\_\_\_ Diploma \_\_\_\_\_  
Degree \_\_\_\_\_

Typical grades received:  above average     average     below average

Did you ever repeat a grade?  Yes     No

Were you ever expelled or suspended?  Yes     No    If Yes, Explain: \_\_\_\_\_

Extracurricular activities \_\_\_\_\_

Plans to continue education:  want to     undecided     no plans     currently in school

**SOCIAL HISTORY**

Number of close friends \_\_\_\_\_

Memberships (church, clubs, organizations) \_\_\_\_\_

Have you ever been arrested?  No     Yes

Explain \_\_\_\_\_

**MILITARY HISTORY**

No     Yes    Dates \_\_\_\_\_

Branch of Service \_\_\_\_\_

Type of Discharge \_\_\_\_\_

**MEDICAL HISTORY**

Are you currently experiencing any of the following: *(please check)*

<i>Yes</i>		<i>Yes</i>		<i>Yes</i>	
	Abdominal Pain		Backache		Change in Bowel
	Change in Menstrual Pattern		Change in Urinary Pattern		Problems with Joints or Muscles, Bones
	Difficulty Sleeping		Colitis		Cough
	Gastro-Intestinal Problems		Loss of Sexual Interest		Loss of Appetite
	Hearing Problems		Hypertension		Palpitations
	Ulcers		Vomiting		Hypoglycemia
	Shortness of Breath		Problems with Skin		Other:
	Other:		Other:		Other:

List of any medications you are now taking, even if only occasionally:

<i>Name of Medication</i>	<i>Dosage</i>	<i>Reason for Taking</i>

If you have ever been hospitalized for any reason, complete the following:

<i>Hospital/Location</i>	<i>Year</i>	<i>Nature of Problem</i>

List of any prior psychological treatment or counseling:

<i>Organization/Clinician</i>	<i>Year</i>	<i>Nature of Problem</i>

How would you rate the outcome of this counseling? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_