

ACACIA RISING COUNSELING
Roxanne George, PhD, EMDR-C, LMFT (OR T0762, NM 0185271)
Honoring Strength and Diversity in Individuals, Couples, and Families
 94 El Tros Road, Ranchos de Taos, NM 87557-8780; 575-758-4270 (Local); 541-760-8799 (Cell)
 Email: acaciaring@proaxis.com; Website: acaciaring.com; 844-269-6760 (Electronic Fax)

Client Code: _____ Therapist Initials: _____ Today's Date: _____

Welcome to *ACACIA RISING COUNSELING*. Please take a few minutes to complete this form. If you have any questions or concerns about this form, or don't know what to write, please feel free to leave the space blank until you meet with me.

Information About You

Your Name and Address: Full Name: Address: City, State: Zip Code:		Your Phone Number(s): <input type="checkbox"/> Check here if it is ok for me to call you here <input type="checkbox"/> Check here if it ok for me to leave messages here. <i>Is there anything I need to know about contacting you here?</i>								
Date of Birth (mm/dd/yy): Social Security Number:		Emergency Contact Person: Name: Relationship: _____ Phone: _____								
Primary Care Physician: Name: Phone:		<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%; text-align: left;">Current Medications</th> <th style="width: 20%; text-align: left;">Dosage</th> <th style="width: 20%; text-align: left;">Frequency</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Current Medications	Dosage	Frequency			
Current Medications	Dosage	Frequency								
Veteran: YES ___ NO ___	If a Vet, Dates Served:	Disability: YES ___ NO ___								
Gender (Circle One) 1. Female 2. Male 3. Other [<i>specify</i> _____]	Sexual Orientation (Circle) 1. Heterosexual 2. Homosexual 3. Bisexual 4. Transsexual 5. Other [<i>specify</i> _____]	Relationship Status (Circle) 1. Single 2. Partner/Significant Other 3. Married (Legal or Common Law) 4. Separated/Divorced 5. Widowed 6. Other [<i>specify</i> _____]								
Level of Education Completed 1. 11 th Grade or Under 2. High School Diploma/GED/Voc. 3. Some College or AA Degree 4. BA/BS Degree 5. Graduate Degree 6. Other [<i>specify</i> _____]	Ethnic/Cultural Background (Circle) 1. White 2. African-American 3. Latino/Latina/Hispanic 4. American/Alaskan Native 5. Asian/Pacific Islander 6. Mixed Race 7. Other [<i>specify</i> _____]	Religious/Spiritual Orientation 1. Christian 2. Jewish 3. Muslim 4. Hindu 5. Buddhist 6. Spiritual 7. Other [<i>specify</i> _____]								
Employment Status (Circle One) 1. Full-time (36 hrs/wk or more) 2. Part-time (less than 36 hrs/wk) 3. Unemployed w/govt. assistance 4. Unemployed, no govt. assistance 5. Retired or 6. Student 7. Other [<i>specify</i> _____]	Household Income Sources (Circle) 1. Earned income from employment 2. Unemployment benefits 3. Retirement/Pension 4. Child Support 5. Welfare/AFDC 6. SSI/SSDI 7. Other [<i>specify</i> _____]	Household Pre-Tax Annual Income 1. None 2. Less than \$6,000 (< \$500/mo) 3. \$6,001 - \$12,000 (\$500-\$1000/mo) 4. \$12,001-\$24,000 (\$1000-\$2000/mo) 5. \$24,001-\$36,000 (\$2000-\$3000/mo) 6. More than \$36,000 (> \$3,000/mo)								

Referral Source	Phonebook ___	Brochure ___	Professional _____	Other _____
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Information About Your Family

Who currently lives in your home and what is their relationship to you?		
Name	Age	Relation to you?
1.		
2.		
3.		
4.		
5.		

Previous Counseling or Therapy History

Have you seen a counselor or therapist in the past? (if yes, please give the name or agency)	Are you currently seeing another counselor or therapist? (if yes, please give the name or agency and phone number)
May I contact them? YES _____ NO _____	May I contact them? YES _____ NO _____
If you have been in counseling or therapy in the past,	
What was most helpful for you?	
What was least helpful for you?	

About Your Reason For Contacting Me

Please describe your reason for seeking counseling at this time.
How long has this issue been influencing you and your life?
Who else is aware of, involved in, or influenced by this issue? In what ways?
What have you tried to do to resolve the problem?
Did any of these help with the problem? Explain.

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Other Information That May Be Useful In Assisting You (Circle All Italicized & Underlined Items That Apply)

A1) <u>Are you / have you</u> ever been in a relationship where YOU were threatened, stalked, spied on, controlled Circle: <i>financial; social; emotional; damaged/ vandalized property; verbally insulted and/or put you down?</i>	Yes No _____
A1a) If yes, what is the approximate number of single incidents that occurred in the relationship(s)?	_____
A2) <u>Are you / have you</u> ever behaved this way towards SOMEONE ELSE ?	Yes No _____
A2a) If yes, what is the approximate number of single incidents that occurred in any of your relationships?	_____
B1) <u>Are you / have you</u> ever been in a relationship where YOU were <i>physically / sexually</i> mistreated or hurt? (B1a) If yes, what is the approximate number of single incidents that occurred in any of your relationships?	Yes No _____
B2) <u>Are you / have you</u> ever behaved this way towards SOMEONE ELSE ?	Yes No _____
(B2a) If yes, what is the approximate number of single incidents that occurred in any of your relationships?	_____
C1) <u>Are you / have you</u> ever been in a relationship where YOU felt hesitant to express your views?	Yes No
C2) <u>Are you / have you</u> ever been in a relationship where SOMEONE ELSE was hesitant to express views?	Yes No
D1) <u>Are you / have you</u> ever been in a relationship where YOU felt afraid of your partner?	Yes No
D2) <u>Are you / have you</u> ever been in a relationship where SOMEONE ELSE felt afraid of you?	Yes No
Note: Questions E1 through E4 include the use of prescription medications and supplements	
E1) <u>Are you / have you</u> ever been concerned about or negatively impacted by YOUR <i>alcohol / drug</i> use?	Yes No
E2) <u>Are you / have you</u> ever been concerned or negatively impacted by SOMEONE ELSE'S <i>alcohol / drug</i> use?	Yes No
E3) Has anyone ever expressed concern or been negatively impacted by YOUR <i>alcohol / drug</i> use?	Yes No
E4) Have you ever participated in a <i>support group / counseling</i> due to YOUR <i>alcohol / drug</i> use?	Yes No
E5) Have you ever participated in a <i>support group / counseling</i> due to SOMEONE ELSE'S <i>alcohol / drug</i> use?	Yes No
E5) Has someone close to you participated in a <i>support group / counseling</i> due to THEIR <i>alcohol / drug</i> use?	Yes No
F) Have you ever intentionally caused harm to yourself? When / How?	Yes No
G) Have you ever been diagnosed with a mental illness? When / What?	Yes No
H) Are you or have you ever been involved with Child Protective Services? When / Why?	Yes No
I) Are there any current legal involvement's going on in your life? Explain	Yes No
J) Are you or is somebody close to you dealing with any medical concerns? Who?	Yes No
K) Have there been any recent deaths or losses in your family or among your friends? Who?	Yes No
L) Have you or someone close to you had any other recent changes? Explain	Yes No
M) Are you currently experiencing any difficulties in the following areas (check all that apply)	
<input type="checkbox"/> Alertness <input type="checkbox"/> Concentration <input type="checkbox"/> Anxiety/Fidgety <input type="checkbox"/> Menstrual Changes <input type="checkbox"/> Appetite <input type="checkbox"/> Memory Loss or Pblms <input type="checkbox"/> Depression/Sadness <input type="checkbox"/> Reproductive Changes <input type="checkbox"/> Breathing <input type="checkbox"/> Pain Management <input type="checkbox"/> Bipolar/ OCD/IDC <input type="checkbox"/> Sexual Intimacy <input type="checkbox"/> Numbness <input type="checkbox"/> Stomach/Digestion <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Sexual Confusion <input type="checkbox"/> Dizziness/Faintness <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Thoughts of Harming <input type="checkbox"/> Other _____ <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Change in Appetite Self or Others	
N) Is there anything else I didn't ask about that you are struggling with or would like assistance with?	

Family / Relational Assessment

Read each item below to see if it describes how your partner or family member usually treats you. Circle the number that best describes how strongly you agree or disagree with whether it applies to you. Your answers are confidential and will not be shared with your partner.	Do Not Agree At All				Strongly Agree
(1) My partner/family member never admits when he/she is wrong.	1	2	3	4	5
(2) My partner/family member is unwilling to adapt to my needs and expectations.	1	2	3	4	5
(3) My partner/family member is more insensitive than caring.	1	2	3	4	5
(4) I am often forced to sacrifice my needs to meet my partner's/family member's needs.	1	2	3	4	5
(5) My partner/family member refuses to talk about problems that make him/her look bad.	1	2	3	4	5
(6) My partner/family member withholds affection unless it would benefit him/her.	1	2	3	4	5
(7) It is hard to disagree with my partner/family member because he/she gets angry.	1	2	3	4	5
(8) My partner/family member resents being questioned about the way he/she treats me.	1	2	3	4	5
(9) My partner/family member builds himself/herself up by putting me down.	1	2	3	4	5
(10) My partner/family member retaliates when I disagree with him/her.	1	2	3	4	5
(11) My partner/family member is always trying to change me.	1	2	3	4	5
(12) My partner/family member believes he/she has the right to force me to do things.	1	2	3	4	5
(13) My partner/family member is too possessive or jealous.	1	2	3	4	5
(14) My partner/family member tries to isolate me from family and friends.	1	2	3	4	5
(15) My partner/family member sometimes physically hurts me.	1	2	3	4	5
Total Score:					

For each of the items listed below, circle the number that most accurately represents the quality of your current relationship.	Quality of Relationship			
	Poor	Average	Good	Excellent
a. The communication quality/integrity of my relationship (e.g. talking, listening, respect of differing views, non-verbal cues, making time) is...	1	2	3	4
b. The friendship quality / integrity of my relationship (e.g. shared interests or hobbies, shared fun & laughter, comfortable & easy to be with, enjoy being with) is...	1	2	3	4
c. The emotional quality / integrity of my relationship (e.g. caring, support, emotional closeness, warmth, ability to hear/acknowledge/empathize with others' feelings) is...	1	2	3	4
d. The physical quality /integrity of my relationship (e.g. touching, hugging, affection, sexual intimacy, respect of physical boundaries) is...	1	2	3	4
e. The romantic quality / integrity of my relationship (e.g. romance, attraction, fire) is	1	2	3	4

During conflict, I often feel (circle the most appropriate representation) with my partner/family member:



You



Partner/Family Member



You



Partner/Family Member



You



Partner/Family Member

Thank you for taking the time to fill this out. I look forward to being able to assist you!