

# Erik Bohlin, M.A., P.S.

## New Hope Counseling

### WELCOME TO NEW HOPE COUNSELING!

To help me serve you better, your cooperation in completing this questionnaire will be helpful in planning our services for you.

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mailing  
Address: \_\_\_\_\_  
Street or P. O. Box

\_\_\_\_\_

City	State	Zip Code
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Telephone(s): \_\_\_\_\_ / \_\_\_\_\_  
(home) (work)

Check box  if you if you do not wish us to contact you by mail for phone

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Person who does not live with you to contact in emergency:

Name	Phone	Relationship
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How were you referred us? \_\_\_\_\_

Briefly Describe Your Reason for Seeking Help:

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**MEDICAL INFORMATION**

When were you last examined by a Physician? \_\_\_\_\_

Name of your Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone \_\_\_\_\_

May we contact your physician if necessary? \_\_\_\_\_

List any major health problems for which you currently receive treatment:

\_\_\_\_\_

List any medication you are now taking:

\_\_\_\_\_

Have you ever received psychiatric or psychological help or counseling of any kind before? \_\_\_\_\_ If you have, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROBLEM LIST**

Please circle any of the following problems which pertain to you:

- |                 |                   |                  |                |                  |
|-----------------|-------------------|------------------|----------------|------------------|
| Nervousness     | Depression        | Guilt            | Shame          | Meaninglessness  |
| Crying Spells   | Shyness           | Sexual Problems  | Fears          | Separation       |
| Divorce         | Suicidal Thoughts | Drug Use         | Alcohol Use    | Finances         |
| Anger           | Self-Control      | Friends          | Sleep          | Anxiety          |
| Unhappiness     | Relaxation        | Stress           | Work           | Legal Matters    |
| Headaches       | Tiredness         | Energy           | Memory         | Ambition         |
| Loneliness      | Insomnia          | Making Decisions | Education      | My Thoughts      |
| Inferiority     | Concentration     | Temper           | Career Choices |                  |
| Health Problems | Children          | Nightmares       | Marriage       | Unresolved Grief |
| Stomach Trouble | Weight Gain/Loss  | Parenting        | Appetite       | Spiritual Issues |

Please add any additional information which you feel may be useful to your therapist:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR FAMILY MEMBERS**

Include all persons who live in your home including your spouse and your children, and/or anyone living with you for whom you assume personal or family responsibility, and also any children no longer living in your home.

Name Relationship Age Birth date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Marital History**

Spouse's Name \_\_\_\_\_  
Length of Marriage \_\_\_\_\_ Length of Engagement \_\_\_\_\_  
Separated? \_\_\_\_\_ Divorced? \_\_\_\_\_ Deceased \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Length of Marriage \_\_\_\_\_ Length of Engagement \_\_\_\_\_  
Separated? \_\_\_\_\_ Divorced? \_\_\_\_\_ Deceased \_\_\_\_\_

**Family History**

Name Age Education/Occupation  
Father: \_\_\_\_\_

Mother: \_\_\_\_\_

