Mayo Psychological Services

1640 Powers Ferry Road

Building 17, Ste. 350

Marietta, GA 30067

Dear New Client:

Welcome, and thank you for choosing **Mayo Psychological Services**. We request that you complete this paperwork prior to your initial visit.

If **Dr. Mayo** is a participating provider in your insurance network, and you would like to utilize your insurance for your first and subsequent appointments, you will need to fill out all insurance information requested on the following forms. It is important that any pre-authorization that may be necessary is obtained **prior** to your initial visit.

In order to avoid having to use your designated session time to complete the enclosed forms, please bring all the completed forms with you to your first visit.

If you have any questions, please do not hesitate to contact us.

We look forward to seeing you.

PRE-COUNSELING PROFILE

The following information will become a part of your confidential file. This will help us to focus more clearly on the areas of concern that you may desire to work on through counseling. Please answer each question as completely and carefully as you can.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Office #: _____ Cell #: _____

Preferred method of communication: ☐ Home ☐ Office ☐ Cell Phone Call ☐ Text message

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Occupation: _____ Hrs. Work Weekly: _____

Presently living with: ☐ Parents ☐ Spouse ☐ Alone ☐ Other: _____

Employer: _____

Current Marital Status: ☐ Single ☐ Married ☐ Remarried ☐ Separated

☐ Divorced ☐ Widowed

Educational Background:

Circle last year of school completed: Grade School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12 College: 1 2 3 4 5 6+

Medical/Counseling Background:

Describe any physical problems or handicaps you have that may require medication or physical care: _____

Are you currently receiving medical treatment: Yes☐ No☐

If yes, for what purposes?

_____

_____

Have you used drugs for other than medical purposes? ☐ Yes ☐ No

If so, what drugs? _____ With whom? _____

Have you been in counseling/therapy/mental healthcare before? ☐ Yes ☐ No

If yes, when? _____ For what reason? _____

_____

Have you ever taken medication prescribed for emotional reasons? ☐ Yes ☐ No

If yes, when? _____ For what reason?_____

_____

Are you currently taking medication prescribed for emotional reasons? ☐ Yes ☐ No

If yes, what medication? _____ For what reason? _____

_____

Marital Background

Name of Spouse: _____ Occupation _____

Is your spouse willing to participate in counseling? ☐ Yes ☐ No If yes, when? _____

Date of Marriage: _____ Ages when Married: Husband: ____ Wife: _____

Have you ever separated? ☐ Yes ☐ No If yes, when? _____

List all marriages, including current one, in order. Indicate your age at the time of the marriage, how long the marriage lasted, whether it was broken by death or divorce, and the basic reason to the breakup of the relationship, from your perspective: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List and give the following information about each child you have: Name, age, sex, by which marriage, whether the child is married and/or has left home, and any children who may have died. For children who have died, indicate age at time of death and cause of death: _____

Religious Background

Your denominational preference: _____ Active☐ Inactive ☐

Spouse's denominational preference: _____ Active☐ Inactive ☐

What significant spiritual experiences have you been a part of or are currently experiencing?

Family Background

Natural Parents: Remained Married ☐ Separated ☐ Divorced

If separated or divorced, how old were you at the time? _____

Father deceased? Yes☐ No☐ If yes, how old were you at the time? _____

Mother deceased? Yes☐ No☐ If yes, how old were you at the time? _____

Father remarried when you were age _____ Mother remarried when you were age _____

You lived with: Mother☐ Father☐ Foster☐ Other family member☐

What kind of relationship did you have with your step-parents? _____

_____

_____

_____

Natural father's occupation: _____ Natural mother's occupation: _____

Step-father's occupation: _____ Step-mother's occupation: _____

How many times was your father married? _____ Your mother? _____

Rate your parents' marriage: Unhappy☐ Average☐ Happy☐ Very Happy☐

Their marriage lasted _____ years.

List your brothers, sisters (including step-brothers or sisters) from the oldest to youngest, including yourself, giving their names and ages: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Check the statements that best describe your **Family History**:

- ☐ Warm relationship with father/mother
- ☐ Warm relationship with brothers/sisters
- ☐ Sibling rivalry
- ☐ Father/mother absent physically/emotionally
- ☐ Moved frequently
- ☐ Parental job/financial instability
- ☐ Relatives lived nearby
- ☐ Close relationship with grandparents/aunts/uncles/cousins
- ☐ Alcohol/drug abuse/other compulsive behavior by father/mothers
- ☐ Addictive/compulsive behavior in other family members
- ☐ Chronic-physical, mental or emotional illness in family members
- ☐ Rigid, perfectionist standards
- ☐ Frequent/excessive anger and conflict
- ☐ Physical/emotional/sexual abuse by family members

Problem Areas

In the following list, please place a check mark next to each item which is an area of current concern for you. Place two check marks beside those items which are the highest concern. Please add any comments you wish to make in the space beside them.

☐ Abused as a child _____

☐ Addiction _____

☐ Anger _____

☐ Anxiety _____

☐ Bitterness _____

☐ Depression _____

☐ Eating Disorder _____

☐ Educational Concerns _____

☐ Fear _____

☐ Marital Problems _____

☐ Physical Problems _____

☐ Problems with Social Relations _____

☐ Problems with Children _____

☐ Problems with Parents _____

☐ Religious/Spiritual Concerns _____

☐ Sadness _____

☐ Self-Esteem _____

☐ Sexual Concerns _____

☐ Stress _____

☐ Suicidal Thoughts _____

☐ Trouble Making Decisions_____

☐ Use of alcohol, drugs, or other addictive/compulsive behavior by others_____

☐ Work _____

☐ Worry _____

☐ Other (please describe)_____

_____

_____

Therapy Goals

Please describe the changes that you would like to make in your life and relationships as a result of participating in therapy. Also include any significant life changes or stressful events you have recently experienced._____

_____

_____

_____

_____

_____

Do you feel that your need for therapy will be:

☐ A one-time evaluation/referral

☐ Short-term (6-8 sessions over 3-6 months)

☐ Long-term (10+ sessions over more than 6 months)