DSM _____

_____

Burke Counseling & Consulting, Inc.

Gwendolyn Burke, LCSW, LSCSW John Burke, LSCSW, LCSW

1010 Carondelet Drive, Suite 412 Kansas City, MO 64114

4151 NW Mulberry Drive, Suite 203, Kansas City, MO 64116

205 South 5th Street, Suite 15 -16, Leavenworth, KS 66048

PLEASE **PRINT** CLEARLY

Client's Name **circle M/F** Date of Birth/Age Today's Date
Street Address City State Zip Code
Cell Phone & Carrier (i.e. AT/T) Home Phone Work Phone
Marital Status Last 4 SS Number
Employer Occupation
Employer's Street Address City State Zip Code
Spouse/Significant Other/ Parent if minor Street Address City/State/ Zip Code (if different) Name: SSN: DOB:
Home Phone Work Phone Cell Phone
Employer – Spouse/Significant Other/Parent
Employer's Street Address City State Zip Code
Previous Counseling or Therapy? **NO** **Yes – explain**
Referred By/ Reason for coming to therapy:
Payment Information
Person Responsible for payment (No organizations or insurance companies)
Should my account balance become more than 90 days past due and my account is turned over for collections, I will be responsible for the collection fees as well as any legal cost involved in its collection.
Do you wish your insurance filed? **NO YES**
Insurance Company Street Address City State Zip Code
Name of Insured Social Security Number of Insured
Member ID# Group #
I understand my general payment responsibilities are outlined above and I authorize payment of benefits to Gwendolyn Burke/Burke Counseling & Consulting, Inc. and the release of any information necessary to process the claims.
Signature_____ Date_____

Emergency Contact Person (REQUIRED):

Name:_____Relation_____

Best way to contact:_____

Others living in the home:

Name(s)	Date of Birth	School/Employer

Have you ever felt like you should cut down on your drug or alcohol use? Yes No
Has a friend or relative expressed concerns about your use? Yes No
Have you ever felt guilty about your drinking or drug use? Yes No
Are you a recovering alcoholic or a recovering drug addict? Yes No
Is there a history of problems with drugs or alcohol use in your family? Yes No

How was your job performance rated on your last review? _____
_____
_____

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking:

Check substance you use in any amount at all: **How much do you use per:**

Substance	**Age of first use**	**Weekday**	**Weekend**	**Month**	**Last Used**
Beer					
Liquor					
Marijuana					
Cocaine/Crack					
Methamphetamine/Crystal					
Heroin					
Barbiturates (downers)					
PCP,LSD (hallucinogens)					
Tobacco (in any form)					
Other					

History of treatment for emotional problems and family history:

Outpatient treatment Yes No Did it help? Yes No
Therapist's name _____ Dates of treatment _____

Inpatient treatment No Yes
Where _____
When _____
Length of Stay _____

Is there a family history of emotional problems? Yes No
Who _____
Relationship to you _____

CLIENT REPORT OF PROBLEM

Name _____ Today's Date_____

Briefly describe your reason(s) for seeking help: _____

_____

_____

_____

How long have you had the problem(s)? _____

_____

_____

_____

Why did you decide to seek help now? _____

_____

_____

_____

What other ways have you tried to deal with this problem? _____

_____

_____

_____

Circle all that apply to you:

Thoughts of suicide	Thoughts of harming others	Phobia
Trouble getting to sleep	History of attempts to kill yourself	Panic attacks
Waking during the night	Cutting or otherwise hurting self	Excessive guilt
Financial Problems	Feelings of hopelessness	Forgetfulness
Loss of Appetite	Inability to make decisions	Mood swings
Hearing Voices	Large weight gain or loss	Family Problems
Problems at work	Seeing things others don't	Violence toward others
Trouble Concentrating	History of physical abuse	Tingling and Numbness
Racing Thoughts	History of sexual abuse	Depressed Mood
Legal Problems		

Are you currently having thoughts of suicide? No Yes – what is your plan - explain

_____

_____

Are you currently having thoughts of homicide? No Yes – Who would you harm?
What is your plan – explain _____

_____

_____

HEALTH INFORMATION

	CLIENT	**SPOUSE**	**PARENTS (if minor client)**
Present Health:			
Medical concerns:			

Health Status

List any medical problems or physical problems and when they were diagnosed:

1. _____
2. _____
3. _____
4. _____

List any major surgeries (where you were put to sleep) you have had to date:

1. _____
2. _____
3. _____
4. _____

List any serious illness or injuries especially anything involving the head:

1. _____
2. _____
3. _____
4. _____

List any allergies to food or drugs:

1. _____
2. _____
3. _____
4. _____

Medical Information

Primary Care Physician:			Date of last visit:
Address	City	State Zip Code	Phone#
Psychiatrist:			Date of last visit:
Address	City	State Zip Code	Phone #
May we contact your doctor(s)? No Yes			
Signature_____			