

# Pamela J. Bolen Counseling

6222 Colleyville Boulevard Suite A, Colleyville, TX 76034  
817-416-5867

## Client Information:

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Please indicate by checking where we may leave a message: Home\_\_ Work\_\_ Cell\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male:\_\_\_ Female:\_\_\_ Social Security: \_\_\_\_\_

Marital Status: Single:\_\_\_ Relationship:\_\_\_ Married:\_\_\_ Separated:\_\_\_ Divorced:\_\_\_  
Widowed:\_\_\_

Name of spouse/significant other \_\_\_\_\_ Children's names and ages \_\_\_\_\_

Identify any previous marriages: \_\_\_\_\_

Identify any history of psychiatric/emotional/drug or alcohol problems and treatment in your Current Family and in your Family of Origin: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

City \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

Zip \_\_\_\_\_ Occupation: \_\_\_\_\_

Education (Highest level completed) \_\_\_\_\_

Name of any school currently attending and grade \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_

Cell phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_

## Health Information

Please rate your health: Very Good\_\_ Good\_\_ Average\_\_ Declining\_\_

Recent weight changes: Lost\_\_ Gained\_\_

Recent changes in sleep patterns: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Report from most recent exam: \_\_\_\_\_

List all important past or present injuries, illnesses or disabilities: \_\_\_\_\_

Are you currently taking any medication? Yes\_\_\_ No\_\_\_ if yes please list them with dosages \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Have you ever used drugs for other than prescribed medical purposes? Yes\_\_\_ No\_\_\_

If yes please list them \_\_\_\_\_

Have you ever had a severe emotional upset? If so, please explain: \_\_\_\_\_

Have you ever terminated a pregnancy? If yes, when: \_\_\_\_\_

Have you ever had a miscarriage? If yes, when: \_\_\_\_\_

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**Other Information:**

Have you ever been arrested?

Are you currently dealing with any legal issues?

Are you willing to complete and sign a release of information so your psychiatric or medical may be obtained? Yes\_\_\_ No\_\_\_ please explain \_\_\_\_\_

Have you recently suffered loss from serious personal, social, business, or other reversals? Yes\_\_\_ No\_\_\_ Explain \_\_\_\_\_

Have you ever been a victim of a crime? Yes\_\_\_ No\_\_\_

If so, have you filed with Texas Crime Victims Compensation? Yes\_\_\_ No\_\_\_

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**Religious/Faith Background**

Current Faith involvement \_\_\_\_\_

Please explain any recent changes in your spiritual life \_\_\_\_\_

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**Personality Information**

Have you ever had any counseling or therapy before? Yes\_\_\_ No\_\_\_

Outcome \_\_\_\_\_

Please list approximate dates and names of counselors \_\_\_\_\_

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Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment? Yes\_\_\_ No\_\_\_ If yes, please list facility and dates, and indicate if

you completed the program successfully: \_\_\_\_\_

Please circle any of the following words which best describe you now: active, ambitious, self-confident, persistent, nervous, hardworking, impatient, impulsive, moody, often-blue, excitable, imaginative, calm, serious, easy-going, shy, good-natured, introvert, extrovert, likable, leader, follower, quiet, stubborn, submissive, lonely, self-conscious, sad, fatigued, anxious, sensitive, optimistic, sees the glass half empty, stressed, other \_\_\_\_\_

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**Consent**

How were you referred? \_\_\_\_\_

May we send them a thank you note for their recent referral without using your name? \_\_\_\_\_

Please read and initial in the space provided. I understand and agree that I am ultimately responsible for payment at the time services are rendered. I have also read and received a copy of Clients Rights and Information. \_\_\_\_\_ I hereby consent for therapeutic services provided by Pamela J. Bolen.

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Client's Signature

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Date

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Counselor's Signature

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Date

I attest that I am the legal guardian or managing conservator of this minor child, \_\_\_\_\_ with rights to consent to medical treatment for this minor child and I do hereby consent for counseling services to be provided to this child.

Signature of Guardian or Managing Conservator \_\_\_\_\_

Relationship to child \_\_\_\_\_