



Dear EMERGE Client,

Thank you for entrusting EMERGE Counseling Services to assist with your concerns. Our team of clinical and administrative professionals desire to provide you with the highest quality Christian mental health services.

To help us best serve you, please thoroughly review and complete the attached documents and be sure to note any questions you have about the contents. Thank you for completing these documents prior to your first appointment.

PLEASE NOTE: For Minor Clients (under the age of 18), a Parent/Legal Guardian is required to accompany their child and remain onsite during the child's first appointment. Please check with the clinician for the need of your ongoing involvement in the therapeutic process in subsequent sessions.

Current Custody Documents are required if the client is a minor with divorced parents or if the client is under the care of a guardian or Children's Services. This helps us to appropriately determine consent for care and access to confidential information. Please submit the full document along with the below forms.

Form A - HISTORY FORM - Please print one for each individual seen at EMERGE. For minors, you will need to complete the Child/Adolescent version.

Form B - NOTICE OF PRIVACY PRACTICES - This brochure outlines important information regarding the privacy of your health information. Please review prior to your first appointment.

Additional items that are very important to bring to your first appointment:

- **Insurance cards** for all health plans in which you participate if you plan to access your health insurance benefits.
- **Additional materials** you feel may be helpful to your clinician (e.g. reports, test results from schools, medical and/or mental health professionals, legal documents).
- **Your treatment goals.** How can we best serve you?
- **Your calendar/mobile device** for scheduling appointments.

Should you need to cancel your session, please contact EMERGE Counseling Services as soon as possible (330-867-5603, option 3) so that we may reschedule you. **A 24 hour notice avoids a late cancellation fee.**

Please know that we desire to be helpful to you and to make your experience at EMERGE Counseling Services as beneficial and pleasant as possible. We always welcome your feedback and look forward to a productive and successful relationship. May God richly bless you!

Client Registration Team
EMERGE Counseling Services
330-867-5603 ext 3
intake@emerge.org

HEALTH HISTORY QUESTIONNAIRE

Name: _____ SS # _____
Age: _____ Date: _____

MEDICATION ALLERGIES _____
OTHER ALLERGIES _____
REACTION TO ALLERGIES _____

Please check all conditions that currently or have previously applied.

- | | |
|--|--|
| <input type="checkbox"/> Problems with vision | <input type="checkbox"/> Check if you drink alcohol |
| <input type="checkbox"/> Wear glasses | Type _____ |
| <input type="checkbox"/> Headaches | How often _____ |
| <input type="checkbox"/> Problems with hearing | How much _____ |
| <input type="checkbox"/> Use of a hearing aid | Age first used _____ |
| <input type="checkbox"/> Lung problems | Most recent use _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Check if you use tobacco |
| <input type="checkbox"/> Chronic cough | Type _____ |
| <input type="checkbox"/> Stomach problems | How much _____ |
| <input type="checkbox"/> Ulcers | How often _____ |
| <input type="checkbox"/> Constipation | How long _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Check if you use drugs other than prescribed for you |
| <input type="checkbox"/> Low blood pressure | Type _____ |
| <input type="checkbox"/> High blood pressure | How much _____ |
| <input type="checkbox"/> Dizziness | How often _____ |
| <input type="checkbox"/> Heart disease | First use _____ |
| <input type="checkbox"/> Chest pain | Last use _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Check if you have a history of IV drug use or sharing needles |
| <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Other hormone problems | |
| <input type="checkbox"/> Problems with sense of smell | |
| <input type="checkbox"/> Problems swallowing | |
| <input type="checkbox"/> Swelling in feet, ankles, legs | |
| <input type="checkbox"/> Problems with sexual functioning | |
| <input type="checkbox"/> Currently pregnant | |
| <input type="checkbox"/> Abortions/Miscarriages | |
| <input type="checkbox"/> Menstrual problems...Date of last menstrual period _____ | |
| <input type="checkbox"/> Joint pain | |
| <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Urinary problems | |
| <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Weight gain Amount _____ In what period of time _____ | |
| <input type="checkbox"/> Weight loss Amount _____ In what period of time _____ | |
| <input type="checkbox"/> Problems with appetite | |
| <input type="checkbox"/> Trouble sleeping | |

List any medical illness for which you are presently or have previously been treated _____

Date of last physical exam _____ Where _____

List current prescribed medications, including dose and frequency, that you are taking _____

**RETURNING CLIENT -- CHILD AND ADOLESCENT
HISTORY QUESTIONNAIRE**

Date you completed this form: _____

Person who completed this form: _____

Relationship to child: _____

It is preferable that both parents accompany the child to the first consultation, if possible.

Child's name _____ Birthdate _____ Age ____ Sex ____
 last first middle

Home address _____
 street city state zip

Home telephone number _____

Emergency Contact _____ Telephone _____

Child's school _____ Telephone _____

 Name Grade _____

 Address

PEER RELATIONSHIPS

- My child seeks friendships with peers.
- My child is sought by peers for friendship.
- My child plays primarily with children his or her own age.
- My child plays primarily with younger children.
- My child plays primarily with older children.

Describe briefly any problems your child may have with peers. _____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

- Hyperactivity (high activity level)
- Poor attention span
- Impulsivity (poor self-control)
- Low frustration tolerance
- Temper outbursts
- Sloppy table manners
- Interrupts frequently
- Doesn't listen when being spoken to
- Sudden outbursts of physical abuse of other children
- Acts like he or she is driven by a motor
- Wears out shoes more frequently than siblings
- Heedless to danger
- Excessive number of accidents

Client Name _____

- Doesn't learn from experience
- Poor memory
- More active than siblings or peers

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and an N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age. Then on page 4, list the symptoms checked off on pages 2-4 and write a brief description including age of onset, duration, and any other pertinent information especially noting changes since this child was last seen by our counselor.

- | | | |
|--|---|--|
| ___ Thumb sucking | ___ Night terrors (terrifying night-time outbursts) | ___ Frequent use of profanity to parents, teachers, and other authorities |
| ___ Baby talk | ___ Sleepwalking | ___ Truancy from school |
| ___ Overly dependent for age | ___ Excessive sexual interest and preoccupation | ___ Runs away from home |
| ___ Frequent temper tantrums | ___ Frequent sex play with other children | ___ Violent outbursts of rage |
| ___ Excessive silliness and clowning | ___ Excessive masturbation | ___ Stealing |
| ___ Excessive demands for attention | ___ Frequently likes to wear clothing of the opposite sex | ___ Cruelty to animals, children, or others |
| ___ Cries easily and frequently | ___ Exhibits gestures and intonations of the opposite sex | ___ Destruction of property |
| ___ Generally immature | ___ Frequent headaches | ___ Criminal and/or dangerous acts |
| ___ Eats non-edible substances | ___ Frequent stomach cramps | ___ Trouble with the police |
| ___ Overeating with overweight | ___ Frequent nausea and vomiting | ___ Violent assault |
| ___ Eating binges with overweight | ___ Often complains of bodily aches and pains | ___ Fire setting |
| ___ Undereating with overweight | ___ Worries over bodily illness | ___ Little, if any, guilt over behavior that causes others pain and discomfort |
| ___ Long periods of dieting and food abstinence with underweight | ___ Poor motivation | ___ Little, if any, response to punishment for anti-social behavior |
| ___ Preoccupied with food—what to eat and what not to eat | ___ Apathy | ___ Few, if any, friends |
| ___ Preoccupation with bowel movements | ___ Takes path of least resistance | ___ Doesn't seek friendships |
| ___ Constipation | ___ Tries to avoid responsibility | ___ Rarely sought by peers |
| ___ Encopresis (soiling) | ___ Poor follow-through | ___ Not accepted by peer group |
| ___ Insomnia (difficulty sleeping) | ___ Low curiosity | ___ Selfish |
| ___ Enuresis (bed wetting) | ___ Open defiance of authority | ___ Doesn't respect the rights of others |
| ___ Frequent nightmares | ___ Blatantly uncooperative | ___ Wants things own way with exaggerated reaction if thwarted |
| | ___ Persistent lying | |

Client Name _____

- ___ Trouble putting self in other person's position
- ___ Egocentric (self-centered)
- ___ Frequently hits other children
- ___ Argumentative
- ___ Excessively critical of others
- ___ Excessively taunts other children
- ___ Complains often
- ___ Is often picked on and easily bullied by other children
- ___ Suspicious, distrustful
- ___ Aloof
- ___ "Wise-guy" or smart aleck attitude
- ___ Brags or boasts
- ___ Bribes other children
- ___ Excessively competitive
- ___ Often cheats when playing games
- ___ "Sore loser"
- ___ "Doesn't know when to stop"
- ___ Poor common sense in social situations
- ___ Often feels cheated or treated unfairly
- ___ Feels others are persecuting him/her when there is no evidence for such
- ___ Typically wants her or his own way
- ___ Very stubborn
- ___ Obstructionistic
- ___ Negativistic (does just the opposite of what is requested)
- ___ Quietly or silently defiant of authority

- ___ Feigns or verbalizes compliance or cooperation but doesn't comply with requests
- ___ Drug use
- ___ Alcohol use
- ___ Very tense
- ___ Nail biting
- ___ Chews on clothes, blankets, etc.
- ___ Head banging
- ___ Hair pulling
- ___ Picks on skin
- ___ Speaks rapidly and under pressure
- ___ Irritable, easily "flies off the handle"
- ___ Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.

FEARS

- ___ dark
- ___ new situations
- ___ strangers
- ___ being alone
- ___ death
- ___ separation from parent
- ___ school
- ___ visiting other children's homes
- ___ going away to camp
- ___ animals
- ___ other fears (name) _____
- ___ Disorganized
- ___ Tics such as eye-blinking, grimacing, or other spasmodic repetitious movements
- ___ Involuntary grunts, vocalizations (understandable or not)
- ___ Stuttering
- ___ Depression
- ___ Frequent crying spells

- ___ Excessive worrying over minor things
- ___ Suicidal preoccupation, gestures, or attempts
- ___ Excessive desire to please authority
- ___ "Too good"
- ___ Often appears insincere and/or artificial
- ___ Too mature, frequently acts older than actual age
- ___ Excessive guilt over minor indiscretions
- ___ Asks to be punished
- ___ Low self-esteem
- ___ Excessive self-criticism
- ___ Very poor tolerance of criticism
- ___ Feelings easily hurt
- ___ Dissatisfaction with appearance or body part(s)
- ___ Excessive modesty over bodily exposure
- ___ Perfectionistic, rarely satisfied with performance
- ___ Frequently blames others as a cover-up for own shortcomings
- ___ Little concern for personal appearance or hygiene
- ___ Little concern for or pride in personal property
- ___ "Gets hooked" on certain ideas and remains preoccupied
- ___ Compulsive repetition of seemingly meaningless physical acts
- ___ Shy
- ___ Inhibited self-expression in dancing, singing, laughing, etc.

Client Name _____

- | | | |
|---|---|---|
| _____ Recoils from affectionate physical contact | _____ Frequently pouts and/or sulks | _____ Flat emotional tone |
| _____ Withdrawn | _____ Mute (refuses to speak) but can | _____ Speech noncommunicative or poorly communicative |
| _____ Fears asserting self | _____ Gullible and/or naïve | _____ Hears voices |
| _____ Inhibits open expression of anger | _____ Passive and easily led | _____ Sees visions |
| _____ Allows self to be easily taken advantage of | _____ Excessive fantasizing, "lives in her/his own world" | |

As requested, please first list below symptoms from list above marked with the letter P (for past) and next to each symptom give descriptive information such as when symptom began, how long it lasted, and other important data. Then list symptoms marked with an N (for now) and provide similar information. Please note symptoms that are new or have changed since your last visit.

P or N	Symptom	Brief Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

P or N	Symptom	Brief Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____