MOSAIC
Counseling Services

# Mosaic Counseling Services
## Client Profile
(Please print)

**Date: _____**

**Personal Information**

Last Name: _____ First Name: _____ Middle Name: _____

What is your preferred name: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Date of Birth (Mo./Day/Yr.): _____ Age: _____ Sex: Male _____ Female_____

Please list phone numbers where the counselor may contact you:

Home: (____)_____ May we leave a message? Yes___ No___

Work: (____)_____ May we leave a message? Yes___ No___

Cell: (____)_____ May we leave a message and text you? Yes___ No___

Email _____ May we email you? Yes___ No___
*Please note email correspondence is not considered to be a confidential medium of communication*

Who may we contact in case of emergency (list phone number and relationship):
_____
_____

**Referral Source (Check all that apply):**

- ☐ Mosaic Website
- ☐ Other Website: _____
- ☐ Insurance Company
- ☐ Doctor: _____
- ☐ Employer: _____
- ☐ Church: _____
- ☐ Friend/Family Member
- ☐ Psychology Today
- ☐ Other: _____

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**Request for Counseling**

In your estimation, what is your greatest concern or need?

_____

_____

_____

**Symptoms: (Check all that apply)**

| | | | |
|---|---|---|---|
| ☐ **Anxiety** | ☐ **Sexual Problems** | ☐ **Relationship Problems** | ☐ **Parent/Child Problems** |
| ☐ **Panic Attacks** | ☐ **Thoughts of Suicide** | ☐ **Impulsive Behavior** | ☐ **Personality Problems** |
| ☐ **Depression** | ☐ **Work Problems** | ☐ **Financial Problems** | ☐ **Childhood Trauma** |
| ☐ **Low Self-Esteem** | ☐ **Significant Life Changes** | ☐ **Easily Annoyed/Irritated** | ☐ **Excessive Stress** |
| ☐ **Loss/Grief** | ☐ **Addictions** | ☐ **Abusive Relationship** | ☐ **Difficulty Concentrating** |

If you have been having thoughts of suicide, when was the most recent incident: _____

Have you been treated by, consulted with, or received counseling/therapy from a mental health professional in the past? Yes ___ No___

Are you currently under the care of a mental health professional? Yes___ No___

**Health Information**

Please list any previous therapy or treatment you have received from mental health professionals:

| **Date(s)** | **Name of Therapist/ Place of Therapy** | **Nature of Problem/ Reason for Seeking Therapy** | **Result of Treatment** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list any medications that you are currently taking:

| **Name** | **Dosage** | **Results** |
|---|---|---|
| | | |
| | | |
| | | |

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**Family Information**

What is your marital status: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed___

If applicable, what is your spouse's/partner's name: _____

Please list your children's names, ages and sexes:

_____

_____

_____

**Education and Employment Information**

Please check all that apply to you: High School Graduate ___ Some College Experience ___ College Graduate ___

Trade/Business School Experience ___ Graduate School____

Who is your present/most recent employer:

_____

Length of Employment: _____

By signing below I acknowledge the following:

- I have received or been offered a copy of the Notice of Privacy Practices Form.
- I have received or been offered a copy of the Informed Consent, Policies and Information Form.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Printed Name of Client | Signature of Client | Date |
| _____ | _____ | _____ |
| Printed Name of Parent/Guardian | Signature of Signature/Guardian (If client is under 18) | Date |
| _____ | _____ | _____ |
| Printed Name of Counselor | Signature of Counselor | Date |