



**Shelly Cordsen, LPC**  
 11 Lumpkin St., Suite 100  
 Lawrenceville, Ga 30046  
 678-404-0112  
 scordsen@sprout-counseling.com

SproutCounseling

**PERSONAL & FAMILY HISTORY**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Current Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Highest Level of Education:** \_\_\_\_\_

	Name	If living		If Deceased	
		Age	Health	Year & Age	Cause
<b>Father</b>					
<b>Mother</b>					
<b>Brother(s)</b>					
<b>Sister(s)</b>					
<b>Spouse</b>					
<b>Son(s)</b>					
<b>Daughter(s)</b>					
<b>Other: (Step-parents, children)</b>					

## MEDICAL HISTORY

Are you taking any medicines, drugs, herbs, over-the-counter medications, or vitamins?

Yes \_\_\_ No \_\_\_

If so, list by name and dose. Be SURE to include medicine for: heart, blood pressure, thyroid, pain, sleep, nervousness, depression, epilepsy, birth control, weight reduction or hormones:

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Medical Hospitalizations (list illness, year, and physician): \_\_\_\_\_

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Surgical Hospitalizations (list illness, year, and physician): \_\_\_\_\_

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Other serious illnesses or injuries: \_\_\_\_\_

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Previous psychiatric and/or counseling treatment (practitioner, year, type of treatment, and medication, purpose):

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Current Stressors: \_\_\_\_\_

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Reason for seeking counseling (major problem): \_\_\_\_\_

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How have you addressed these concerns already?

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**Have you had any of these experiences in the past 3 months?**

	Yes	No		Yes	No
Depressed mood?			Sleep disturbance?		
Loss of interest?			Panic attacks?		
Loss of pleasure?			Excessive muscle tension?		
Excessive fatigue?			Excessive nervousness?		
Loss of appetite?			Difficulty breathing/smothering?		
Thoughts of self harm?			Feeling very slowed down?		
Thoughts of harming others?			Dizziness/Faintness?		
Trouble concentrating?			Tremors?		
Weight gain?			Sweating?		
Weight loss?			Tingling/Numbness?		
Agitation?			Flushes/Chills?		
Feelings of unreality?			Fear of losing control?		
Inappropriate elation?			Hallucinations (seeing or hearing things)?		
Inappropriate irritability?			Suspiciousness of several people?		
Grandiose notions?			Overly rapid/Skipping heartbeat?		
Increased pressured speech?			Difficulty remembering/Mind going blank?		
Disconnected, racing thoughts?			Unwanted recurrent persistent thoughts?		
Markedly increased energy?			Repetitive behavior or mental acts that you feel driven to perform?		
Distractibility?			Behaviors or thoughts aimed at warding off some dreaded event?		
Impulse control problem?			Confusion?		
Low self-esteem?			Wide mood swings?		
Nervous habits?					
Social withdrawal?					

**More specific Information you would like for me to know?**

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**What would you like to accomplish through counseling?**

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