Jorgensen Brooks GROUP

CLIENT INFORMATION

Jorgensen Brooks GROUP

Last Name | First Name | Middle Name | Suffix

Type of Referral ☐ Management ☐ Self

Contact

Address | Address 2

City | State | Zip Code

Telephone

Home Phone | Cell Phone | Work Phone

Other Phone | Other Phone Detail

Emergency Contact

Contact Name | Contact Relationship

Home Phone | Cell Phone | Work Phone

Family & Work

Gender | Date of Birth | Age | Relationship Status

Employer

Employer Name | Division

Name of Covered Employee

Family

Family Member Name	Age	Relationship

Medical & Counseling History

Current Medical Problems (Please list all medical problems)

Current Medications (Please list medication name and dosage)

What counseling or treatment have you had in the past?

Current Problem

Briefly describe your reason for contacting us

How many months has this been a concern to you?

How serious would you rate this problem?

☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Have you used our service in the past? (If yes provide details)

Are you having any problems at work?

☐ Absenteeism ☐ Safety ☐ Work Relationships
☐ Quality of Work ☐ Security ☐ Other* _____
☐ Quantity of Work ☐ Tardiness

Details of Other Work Problem

Life Impact

How has this problem affected the following areas of your life?

Marriage or Partner
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Family
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Job or School Performance
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Friendships
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Financial Situation
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Legal Situation
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Health
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Anxiety Level
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Mood
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Eating Habits
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Sleeping Habits
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Ability to Concentrate
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Parenting
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Anger
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Spirituality
☐ Very Minor ☐ Minor ☐ Moderate ☐ Serious ☐ Very Serious

Management Referrals Only

Was this a management referral? ☐ Yes ☐ No

May we contact your manager? ☐ Yes ☐ No

Manager Name _____ Manager Phone _____

Quality Assurance

In order to provide quality assurance, may we call you to ask about your perception of the services rendered? ☐ Yes ☐ No

Where may we call you?
☐ Home ☐ Work ☐ Cell ☐ DO NOT CALL

Where may we leave a message?
☐ Home ☐ Work ☐ Cell ☐ DO NOT CALL

Referral Source

How did you hear about our service?

☐ Brochure ☐ Friend ☐ Other... _____
☐ Co-Worker ☐ Relative
☐ EAP Orientation ☐ Supervisor

Data Entry (Office Use Only)

Record Created By _____

Date Created _____ Time _____