



Joy Groves, MA, LPC, NCC
Licensed Professional Counselor

ADULT INFORMATION FORM

Today's Date _____

Name _____ DOB _____

Address _____ Cell Number _____

_____ Alternate Number _____

_____ Email _____

What is your preferred way for me to reach you? _____

Emergency Contact: Name/relationship _____

Contact Information _____

May I contact him/her in an urgent situation? _____

What brings you to counseling right now?

What do you hope to accomplish in counseling?

When you think about the current concerns you have, how much are affecting you? Choose a number from 1-10. 1 is causing very little discomfort. 10 is so difficult it is almost unbearable.

What are your current/past mental health diagnoses?

Are you on any medications for mental health reasons? If so, what?

Briefly describe your previous counseling experiences, if any:

Have you been hospitalized for a mental health condition? If so, when and for what?

Do you have any current/past physical/medical concerns?

List any significant experiences happening in your life now or in recent years (losses, changes, family issues, financial change, etc). This may include positive changes such as a new job or new child.

List some elements of your support system now. Include supportive people, spiritual support, habits that are healthy for you such as exercise or eating well, hobbies, etc. Anything that provides stress relief, positivity, or an uplift in your life.

Marital Status: M____ Single ____ Div____

Do you have children? What ages?

What is your job, if any, and are you happy with your work situation?

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Child/Student Information Form, completed by parent

Today's date _____

Student Name _____ DOB _____

Student school name and grade _____

Parent/Legal Guardian _____

Parents are: Married and live together _____ Separated _____
Divorced _____ Never married _____ Other _____

Custody arrangement, if indicated:

Contact information for each parent. Circle the primary address of the student.

Name _____

Address _____

Email _____ Phone _____

Name _____

Address (if different) _____

Email _____ Phone _____

How would you like me to contact you? _____

What are your reasons for seeking counseling for your student/family at this time?

Can you list 1-3 goals/hopes you have for counseling?

Summary of previous counseling or psychiatric interventions, including any hospitalizations:

Has your student in the past, or are they currently experiencing self-harm behaviors or suicidal ideation?

Current medications for your student, and what condition they are prescribed for:

Other medical conditions not previously mentioned:

Please list any potentially relevant life experiences that could be affecting your family/student, such as changes, losses, significant experiences (positive or negative), family stressors, traumatic situations or events, etc.

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