Catherine Warnock, MA, LPC, NCC
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RRT Registration Form

Name: _____ Date:_____

Address: _____

Mobile Phone #_____ Alternative Phone #_____

Can I leave a message? ❑Yes ❑No Email: _____
Can I send you a text? ❑Yes ❑No

How did you find or hear about Mariposa Counseling Center? _____

_____

Date of Birth: _____ Age: _____ Gender: _____

Emergency Contact Name: _____
Relationship: _____Phone #: _____

Employer: _____ Occupation: _____

Nationality or Ethnicity: _____ Sexual Orientation: _____

Marital Status: ___Single ___Married___ (years) ___Divorced ___(years)
___Living Together___ (years) ___Separated___ (years) ___Widowed___ (years)

Name of Partner/Spouse: _____

Spiritual/Religious Affiliations: _____

Primary Care Physician: _____ PCP phone #: _____

Have you been in therapy before? ❑Yes ❑No If yes, who and when? _____

_____

Do you have a psychiatrist? ❑Yes ❑No

If yes, who?_____ phone #: _____

Medications (prescriptions, vitamins, supplements, etc.)

Drug	Dose	Frequency	For Treatment of
1.			
2.			
3.			
4.			
5.			
6.			

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Please describe the issue that brought you in today: _____

_____

_____

How many alcoholic drinks do you have…. per day? _____ per week? _____ per month? _____

Please list any other drugs you take for recreational purpose and the frequency of use: _____

_____

List your history of substance use, abuse and/or treatment: _____

_____

Is there a history of substance use or abuse in your family? ❑Yes ❑No

If so, please provide some details _____

_____

Please provide a list of all medical (mental and physical) conditions, diseases, or disorders that you have experienced. Please also note which conditions are current.

_____

_____

_____

Please provide any additional information that you think is relevant to our working together:_____

_____

_____

_____

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Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	**N/A**
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? *Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts*	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	**N/A**	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	**N/A**	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? *Note: Do not answer "yes" for any event you already reported in Questions 1-9*	No Yes	**N/A**	**N/A**

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Current Symptoms Checklist: (check mark the rate the intensity of symptoms currently present)

None= This symptom is not present at this time.
Mild= Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate (Mod)= Significant impact on quality of life and/or day-to-day functioning
Severe= Profound impact on quality of life and/or day-to-day functioning.

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
Depressed mood					Hallucinations: visual				
Stress					Hallucinations: audio				
Change in sleeping habits					Dissociative states				
Muscle tension					Change in libido				
Physical pain					Change in eating habits				
Fatigue/low energy					Significant weight gain/loss				
Poor concentration					Anorexia				
Worthlessness					Binge eating				
Hopelessness					Purging/vomiting				
Mood swings					Laxative/diuretic use				
Emotionality/labile					Substance abuse				
Elevated mood					Somatic complaints				
Agitation					Sexual dysfunction				
Anger/Irritability					Self-mutilation				
Social isolation					Guilt				
Conduct problems					Grief				
Oppositional behavior					Relationship problems				
Aggressive behaviors					Domestic Violence **(V) ***				
Hyperactivity					Domestic Violence **(P)***				
Generalized anxiety					Emotional trauma **(V)***				
Panic attacks					Emotional trauma **(P)***				
Phobias					Physical trauma **(V)***				
Obsessions					Physical trauma **(P)***				
Compulsions					Sexual trauma **(V)***				
Delusions					Sexual trauma **(P)***				
Sadness					Suicidal Thoughts				
Feeling fearful					Acting violently				
Memory problems					Thoughts of hurting others				
Nightmares/Night Terrors					Flashbacks				
Lack of enjoyment in usual activities					Trouble performing at work/school				

*** V=victim P=perpetrator**

Please provide any additional information regarding the above symptoms here: _____

_____

_____

_____