APEIRON
WELLNESS CENTER

Apeiron Wellness Center, PLLC
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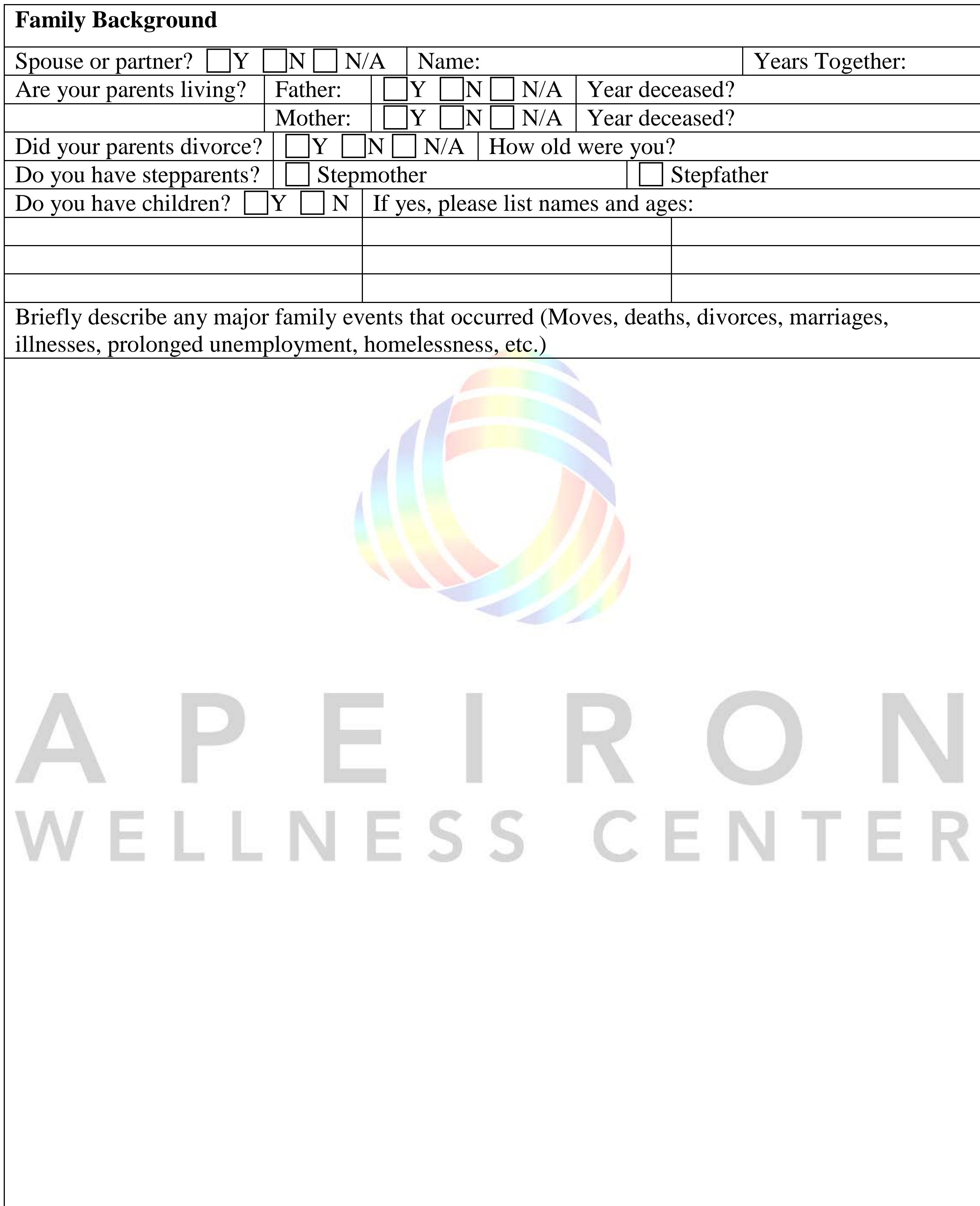
			Date:		
First Client Name:					
Birth date:	Education:		Occupation:		
Gender Identity:	Gender Queer ☐	Other:		Female ☐	Male ☐
Second Client Name:					
Birth date:	Education:		Occupation:		
Gender Identity:	Gender Queer ☐	Other:		Female ☐	Male ☐
Address:					
City:			Zip:		
Client 1 Phone:			Client 2 Phone:		
If we call, may we leave a message?	☐Y	☐N	If we call, may we leave a message?	☐Y	☐N
Email:					
Note: HIPPA requirements state that Apeiron Wellness Center must obtain your written permission to contact you via mail, email, or phone, etc.					
May Apeiron Wellness Center send mail to your listed address above? (ex: newsletter or business mail) to the above physical address?				☐Y	☐N
May Apeiron Wellness Center send mail to your listed address above? (ex: newsletter or business mail) to the above email address?				☐Y	☐N
How did you find us?					
Web Search ☐	Medical Professional ☐	Friend ☐	Other ☐		
Terms?	Who?	Who?			

Family Background				
Spouse or partner? ☐Y ☐N ☐ N/A	Name:			Years Together:
Are your parents living?	Father:	☐Y ☐N ☐ N/A	Year deceased?	
	Mother:	☐Y ☐N ☐ N/A	Year deceased?	
Did your parents divorce?	☐Y ☐N ☐ N/A	How old were you?		
Do you have stepparents?	☐ Stepmother	☐ Stepfather		
Do you have children? ☐Y ☐ N	If yes, please list names and ages:			
Briefly describe any major family events that occurred (Moves, deaths, divorces, marriages, illnesses, prolonged unemployment, homelessness, etc.)				



Physical Health History

How do you rate your overall health?

Are you taking any prescription medications, vitamins, herbal remedies? If so, please list what they are, and what they're for, (e.g. Prozac = depression):

Have you ever been hospitalized? ☐Y ☐ N If so, for what? (Only things in the last 3 years OR related to your current issue or problem):

Do you have, or have you had, any of the following:

	Y	N	Details, frequency, severity
Chronic pain	☐	☐	
Migraines/headaches	☐	☐	
Stomach problems	☐	☐	
Thyroid issues	☐	☐	
Cancer	☐	☐	
Heart Disease	☐	☐	
Diabetes	☐	☐	
Carpel tunnel	☐	☐	
Numbness, tingling	☐	☐	
Panic/anxiety attacks	☐	☐	
Depression	☐	☐	
Feeling spacey or "out of body"	☐	☐	
Phobias/fears	☐	☐	
Extreme fatigue/little energy	☐	☐	
General anxiety	☐	☐	
Sleep issues	☐	☐	**If yes, check any that apply:**

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Sleeping Too Much ☐ Sleeping, waking, and unable to fall back to sleep

How many hours a night do you sleep? Is that amount of sleep usual for you? ☐Y ☐ N

Please rate your overall energy level by filling in the blank for the following sentence…
"I am exhausted/tired and have little energy …"

☐ Always ☐Most of the time ☐ Half of the time ☐ Sometimes ☐ Rarely ☐ I have plenty of energy

Any syndrome, disease, condition, or illness we need to be aware of? ☐Y ☐N
If yes, what?

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Mental Health Background		
Please answer the following questions to the best of your understanding:		
"I have lost interest in many things I once enjoyed doing."		
"I have racing thoughts and find it difficult to concentrate."		
"I feel afraid much of the time."		
	Y	N
Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
Have you actually had any thoughts of killing yourself?	☐	☐
Have you been thinking about how you might kill yourself?	☐	☐
Have you had these thoughts and had some intention of acting on them?	☐	☐
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	☐	☐
Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐	☐
If YES to any: How long ago did you do any of these?		
(Columbia-Suicide Severity Rating Scale. Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann © 2008 The Research Foundation for Mental Hygiene, Inc.)		
Why did you make the effort to call a professional counselor?		
What would you like to see happen as a result of counseling?		
The thing that concerns me the most now is?		
Is there anything else you think it important for the counselor to know right now?		
Please list any major changes or stressors in your life in the last 12 months: (ex: separation, divorce, death of a family member, loss of a job, major illness, moving, etc.)		

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