**Donna Kirby Counseling, LLC**
**Donna Kirby, MS, LPC-S**
**Licensed Professional Counselor Supervisor**
**12800 Hillcrest Rd. Suite A 224**
**Dallas, TX 75230**
**214-507-0448**

## PERSONAL DATA:

Date:_____

Name:_____

Address:_____

City:_____ Zip:_____

Telephone number: _____(day) _____ (evening)

Email:_____

Ok to leave message at above numbers? Yes ___No____

Date of birth:_____ Age: _____ Occupation:_____

Who referred you?_____

With whom are you now living? (list people)_____

_____

_____

Where do you reside? ____house ____hotel ____room ____apartment ____other

Place of Birth_____

---

## Clinical Information:

What is happening in your life which resulted in this appointment?

_____

_____

_____

_____

What would you like to see accomplished in therapy?

_____
_____
_____
_____

Whom have you previously consulted about your present problem(s)?

_____
_____

Are you taking any medication? If “yes”, what, how much, and with what results?

_____
_____

What is there about your present *behavior* that you would like to change?

_____
_____
_____
_____

What feelings do you wish to alter (e.g., increase or decrease)?

_____
_____
_____

**Medical History**
Physician's Name
_____

Address _____ City _____ State/Zip _____

Current Medications
_____
_____
_____

Check the behaviors and symptoms that occur to you more often than you like them to take place:

| | | |
|---|---|---|
| _____ aggressions | _____fatigue | _____sexual difficulties |
| _____ alcohol dependence | _____hallucinations | _____sick often |
| _____ anger | _____heart palpitations | _____sleeping problems |
| _____ antisocial behavior | _____high blood pressure | _____speech problems |
| _____ anxiety | _____hopelessness | _____suicidal thoughts |
| _____ avoiding people | _____impulsivity | _____thoughts disorganized |
| _____ chest pain | _____irritability | _____trembling |
| _____ depression | _____judgment errors | _____withdrawing |
| _____ disorientation | _____loneliness | _____worrying |
| _____ distractibility | _____memory impairment | _____other (specify) |
| _____ dizziness | _____mood shifts | _____cutting |
| _____ drug dependence | _____panic attacks | _____ |
| _____ eating disorder | _____phobias/fears | _____ |
| _____ elevated mood | _____recurring thoughts | _____ |

List additional illness, physical conditions or complaints:
_____
_____
_____