TORI DABASINSKAS, MFC, LPCC

WA LICENSE: LF60424732
CA LICENSE: MFC37796

Initial Summary

Client Name/s: _____ Date: _____

Chief Complaint: _____

Previous Therapy (circle): Counselor Group Family Therapy Hospitalization

Current Medications:
Drug: _____ Dose: _____ Reason: _____
_____ _____ _____
_____ _____ _____

Alcohol Use (circle): Daily Every Now and Then Weekends

Drug Use: Drugs of Choice _____ Frequency _____

In the past 12 months (circle or fill in):

Death of loved one	Change Employment	Move
Relationship Break Up	Church Transition	Self Harm: cut/burn/etc.
Suicide Attempt	Anorexia / Bulimia	Financial Loss
Miscarriage/Abortion	Panic Attacks	Migraines
Legal Issues	Hospitalization	Pregnancy

Other _____

Spiritual Preference: _____

Hobbies/Interests: _____

Current Living Situation (circle): House Apartment Room/Board Other

Recent Medical Care in Past 12 months:
Doctor: _____ Reason: _____
_____ _____

Exercise: (circle): Very Good Good Fair Poor
Nutrition (circle): Very Good Good Fair Poor

Sleep: _____ Sleep Apnea: Y N Unknown

Short Term Counseling Goal: _____

Long Term Counseling Goal: _____

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