**Client History and Information**

**Basic Information:**

Date:

Patient Name:

Date of Birth:

Gender:  [ ] Male   [ ] Female

Ethnicity:

Home Address:

Home Phone Number:                               May we leave a message? [ ] Yes  [ ] No

Work Phone Number:                                May we leave a message? [ ] Yes  [ ] No

Mobile Phone Number:                             May we leave a message? [ ] Yes  [ ] No

If the above patient is a minor complete the following:

Name of Guardian:

Address of Guardian:

Guardian’s Home Phone:                           May we leave a message? [ ] Yes  [ ] No

Guardian’s Work Phone:                            May we leave a message? [ ] Yes  [ ] No

Guardian’s Mobile Phone:                         May we leave a message? [ ] Yes  [ ] No

**Referral Source**

Who referred you to our office, or how did your learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

**History Information**

Who is providing the history information?

[ ] The patient

[ ] The patient’s guardian

[ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

[  ] Substance abuse/dependence

[  ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)

[  ] Depression/Sad/Down feelings

[  ] High/Low energy level

[  ] Angry/Irritable

[  ] Loss of interest in activities

[  ] Difficulty enjoying things

[  ] Crying spells

[  ] Decreased motivation

[  ] Withdrawing from people/Isolation

[  ] Mood Swings

[  ] Black and white thinking/All or nothing thinking

[  ] Negative thinking

[  ] Change in weight or appetite

[  ] Change in sleeping pattern

[  ] Suicidal thoughts or plans/Thoughts of hurting yourself

[  ] Self-harm/Cutting/Burning yourself

[  ] Homicidal thoughts or plans/Thoughts of hurting others

[  ] Poor concentration/Difficulty focusing

[  ] Feelings of hopelessness/Worthlessness

[  ] Feelings of shame or guilt

[  ] Feelings of inadequacy/Low self-esteem

[  ] Anxious/Nervous/Tense feelings

[  ] Panic attacks

[  ] Racing or scrambled thoughts

[  ] Bad or unwanted thoughts

[  ] Flashbacks/Nightmares

[  ] Muscle tensions, aches, etc.

[  ] Hearing voices/Seeing things not there

[  ] Thoughts of running away

[  ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[  ] Feelings of frustration

[  ] Feelings of being cheated

[  ] Perfectionism

[  ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[  ] Distorted body image (believe you are heavier or less attractive than others say you are)

[  ] Concerns about dieting

[  ] Feelings of loss of control over eating

[  ] Binge eating/Purging

[  ] Rules about eating/Compensating for eating

[  ] Excessive exercise

[  ] Indecisiveness about career

[  ] Job problems

[  ] Other:

**Previous Treatment**

Have you received or participated in previous counseling and/or therapy?

[ ] Yes  [ ] No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns?

[ ] Yes  [ ] No

Additional Information:

Are you currently experiencing thoughts of harming either yourself or someone else?

[ ] Yes    [ ] No

Have you in the past experienced thoughts of harming either yourself or someone else?

[ ] Yes    [ ] No

**Developmental History**

Are you aware of any difficulties or complications during the time your mother was pregnant with you?

[ ] Yes   [ ] No

If yes, explain:

Did you walk, talk, and read on time?

[  ] Yes [  ] No

Explain:

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

Are you satisfied at where you are in your life?

If not, where would you like to be?

**Medical History**

List any current or important past medications

Medication & Dose:                                                 Response to Medication:

History of serious childhood illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

Have you experienced any head injuries?

[ ] Yes  [ ] No

Important Details:

If yes, did you lose consciousness?

[ ] Yes   [ ] No

Have you experienced convulsions or seizures?

[ ] Yes  [ ] No  If yes, did you also have a fever? [ ] Yes  [ ] No

Explain any allergies you have:

How would you rate your current physical health?

[ ] Excellent

[ ] Very Good

[ ] Good

[ ] Fair

[ ] Poor

[ ] Very Poor

What was the date of your last physical or routine health “check up?”

Do you have a primary care physician?

[ ] Yes   [ ] No

If yes, complete the following:

Name

Address

Phone Number

**Family History**

Birth Location:

Raised by:  [  ] Mother   [  ] Father   [  ] Step-Mother   [  ] Step-Father

[  ] Other:

Relationship with parent figures:

(good, fair, poor, close, distant, etc.)

Mother:

Father:

Step-parent:

Other:

List your siblings and describe your relationship with them?

Name

Age

Gender

Nature of Relationship

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Any Additional Family Information:

**Social History**

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Are you spiritual? If so, describe:

**Educational History**

When attending school where you:

[  ] In regular classes

[  ] Home Study

[  ] Special classes

[  ] Advanced classes

[  ] Ever suspended

[  ] Placed in alternative school

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school?  Have a learning disability?)

**Occupational History**

What is your current employment status?

[ ] Employed Full-Time

[ ] Employed Part-time

[ ] Unemployed

[ ] Self-employed

[ ] Student

[ ] Other

Are you satisfied with your employment?

If not, why?

**Marital History**

Which best describes your marital status?

[ ] Married, Date: \_\_\_\_\_\_

[ ] Never Married

[ ] Widowed, Date: \_\_\_\_\_

[ ] Separated, Date: \_\_\_\_\_

[ ] Divorced, Date:\_\_\_\_\_\_\_

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction?

[ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

Name

Date

Nature of Relationship

Do you have children?

[ ] Yes [ ] No

If yes, complete the following:

First Name

Age

Gender

Nature of Relationship

Are there presently any child custody issues involving you or your family?

[ ] Yes   [ ] No

Does your family currently have Child Protective Services Involvement?

[ ] Yes   [ ] No

If yes please complete the following:

Case Worker’s Name:

Phone:

**Substance Abuse History**

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes

[ ] No

If you answered yes, please complete the following substance abuse history chart.

Substance

Ever Used Yes/No

Age of First Use

Frequency of Use

(Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.

Alcohol

Marijuana

Cocaine or Crack

Heroin

Amphetamines

Club Drugs (Ecstasy, Inhalants, etc.)

Pain Medication (Oxycontin, Vicodin, etc.

Benzodiazepines

Hallucinogens

Other

Complete the following chart if you have ever received treatment for a substance abuse issue.

Name of Treatment Program

Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)

Date of Treatment (Month, Year)

Outcome (Any Clean time?)

**Legal History**

Do you currently have any pending criminal charges?

[ ] Yes   [ ] No

Are you on probation?

[ ] Yes   [ ] No

Name of Probation Officer and County

Have you ever been arrested/convicted of a crime?

[ ] Yes  [ ] No:  If yes, complete chart.

List any Arrests/Convictions

Date of Arrests/Convictions

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

**Treatment Planning**

What are two main goals you have for counseling?

1.

2.

Name 3 things you would like to change about yourself.

What are your strengths?

How could these strengths help you to reach your goals?

Describe a time in your life when things were going really well:

If you were to rate your *overall* well-being on a scale of 1 (I’m feel terrible) to 10 (I feel fantastic), what number would you give yourself?

1 2 3 4 5 6 7 8 9 10

Using the same scale, where would you like to be at the end of therapy?

1 2 3 4 5 6 7 8 9 10

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or guardian                             Date