Marlene Travis, PLLC
Marlene Travis, MS, MEd, LMHCA, NCC

Client Health Information

The following information is helpful for both clinical reasons and sometimes emergency situations.

Name: _____ Date: _____

Date of Birth: ____/____/____ Age: _____ Referred by: _____

Address: _____

City, State & Zip: _____

FOR CONTACT INFO: do you consent to a message being left on voicemail and/or to whomever answers?

Home phone: _____ (msg ok on VM? yes/☐ msg ok to person? yes/☐

Cell phone: _____ (msg ok on VM? yes/☐ msg ok to person? yes/☐

Other phone: _____ (msg ok on VM? yes/☐ msg ok to person? yes/☐

Email: _____ (msg ok? yes/☐ E-mail communication is NOT secure)

CIRCLE which way(s) of communication you prefer for appointment/billing details: Phone Email Text

Emergency Contact Person: _____ Phone: _____

Relationship: _____

Supportive people in your life: _____

What is your reason for seeking counseling therapy (please be specific): _____

_____

_____

_____

What have you tried so far and how has it worked? _____

_____

_____

_____

What do you hope to accomplish in counseling within 3 to 6 months (what will be different)? _____

_____

_____

_____

ABOUT YOU

Your Strengths: _____

Ways of Coping: _____

Hobbies/ Interests: _____

Cultural, spiritual or religious beliefs or practices that influence you: _____

_____

Importance of your faith in your life (circle one): ☐ not at all ☐ somewhat ☐ very

Counseling History (check all that apply)

☐ I am involved with other counseling services now with _____

☐ I have been involved in counseling in the past with _____

☐ I have attempted suicide (When?)_____

☐ I have had thoughts about hurting myself or someone else now or in the past. _____

☐ I have been hospitalized for psychiatric reasons (When? How long?)_____

☐ Someone in my family has had emotional problems, been hospitalized for psychiatric reasons or attempted suicide.

_____

Physical Health My general health on a scale 1-10:

Date of Last Physical: _____ My Physician: _____

☐ I have some health problems now: _____

☐ I have had some health problems in the past: _____

Current Medication/ Dose	Prescribed by	How long/ How has it worked?

Additional information regarding physical health _____

_____

_____

Substance Use History

Client history: _____

_____

Family history (Parents/Siblings/Extended) : _____

_____

_____

Education/Vocation Years of education: _____ Degrees or areas of study:_____

Vocation: _____ Military service? _____

Current/most recent employment (general performance/satisfaction) _____

_____

Do you have work related problems? Fired. History of leaving jobs? Lateness? Absenteeism? Relating to others? Explain.

_____

Safety Concerns Do you have any concerns about your safety or the safety of someone else? Yes / No (circle)

Comments: _____

_____

Significant Life Events Significant life events can impact current choices. Check any you would like to address

☐Sexual abuse ☐Witness/Victim of DV ☐Personal losses ☐Other: _____

☐Physical abuse ☐Serious Illness/Accident ☐Poor school performance _____

☐Emotional abuse ☐Difficult life changes ☐Harming myself, others, animals or property

COMMENTS _____

_____

STRESS in Life Domains Check any current areas of stress:

☐School	☐Clothing	☐Parenting
☐Work/Unemployment	☐Transportation	☐Sleep (nightmares, etc.)
☐Money	☐Safety	☐Disability
☐Legal/Law/Jail	☐Social (friends, relationships)	☐Chronic Pain
☐Housing	☐Recreation (ways to have fun)	☐Food/Nutrition/Eating

☐Daily living activities - dressing, bathing, brushing teeth, going to school or social events or work, doing homework,etc

☐Additional information: _____

_____

OTHER Possible Stressors – Check all that apply. Briefly explain where appropriate.

Current stressors: _____

_____

Debt? Explain: _____

Gambling? Explain: _____

Pornography? Masturbation? Explain: _____

Family violence (actual or threatened)? Explain: _____

_____

History of physical/sexual abuse or neglect? Explain: _____

_____

Self-cutting? Explain: _____

Eating disorders? Explain: _____

Substance use? Explain: _____

Lying? Explain: _____

Current and past legal involvement (DWI, litigation, incarceration). Explain: _____

_____

_____

PSYCHOSOCIAL HISTORY

Social/Family

Born/raised: _____

Parents: Give a couple adjectives to describe each parent as you were growing up: _____

_____

_____

Family History (i.e., marriages, divorces, significant losses, siblings, etc.): _____

_____

_____

Childhood: _____

_____

_____

Children (names/ages, any concerns):_____

_____

Current relationships (with whom, quality, concerns): _____

_____

History of previous intimate relationships (current and past, duration, why terminated): _____

_____

Relevant lifestyle changes: _____

_____

RATE YOUR LEVEL OF DIFFICULTY (0 to 10)
on a scale of 0 (no problem) to 10 (serious problem)

Your Physical Function

____ Impaired sleep
Too much/not enough
____ Appetite changes
Weight loss/gain
____ Fatigue / lack of energy
____ Sexual functioning

Your Inner Thoughts

____ Poor concentration
____ Memory problems
____ Worry a lot
____ Think of something repeatedly (obsession)

Your Behavior

____ Others take advantage of you
____ Over-involved in others' lives
____ Keep to yourself most of time
____ Cope by using drugs/alcohol
____ Difficulty asking for help
____ Difficulty with daily routine
____ Violent toward yourself
____ Violent toward others
____ Do something over and over (compulsion)

Your Feelings & Moods

____ Sudden changes in mood
____ Easily Frustrated
____ Angry / Irritable
____ Anxiety
____ Nervousness
____ Depressed
____ Sad
____ Crying
____ No longer enjoy things you used to
____ Don't like yourself
____ Feelings of worthlessness,
____ Feelings of hopelessness
____ Feelings of loneliness