Client History and Information

Date: _____ Email: _____
Client Name: _____ Age: _____
Date of Birth: _____ Phone: _____
Address: _____
_____
Race/Ethnicity: _____
Religion: _____
Marital Status: □Married □Never married □Separated □Divorced □Widowed
Living Situation: _____

If the above patient is a minor complete the following:

Name of Guardian: _____
Address of Guardian: _____
_____
Phone Number of Guardian: _____ May we leave a message? □ Yes □No

If you will be using insurance to cover a portion of the cost please complete the following and allow us to make a photocopy of your insurance card: □N/A

Primary Insurance Company: _____
Secondary Insurance Company, if applicable: _____
Who referred you to our office, or how did you learn about our practice?
_____

Emergency Contact Information

In case of an emergency, who should we contact?
Name: _____
Relationship: _____
Address: _____
_____
Phone Number: _____

Presenting Problem

Who is providing the history information? □Client □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 or phrases that describe what you are experiencing.

□Substance abuse/dependence/addiction
□Depression/sad/down feelings
□High/low energy level
□Crying spells
□Angry/irritable
□Loss of interest in activities/difficulty enjoying Things
□Mood swings
□Change in weight or appetite
□Change in sleep pattern
□Self-harm/cutting/burning yourself
□Poor concentration/difficulty focusing
□Feelings of hopelessness/worthlessness
□Feelings of inadequacy/low self-esteem
□Withdrawing from people/isolation
□Anxious/nervous/tense feelings
□Panic attacks
□Racing or scrambled thoughts
□Flashbacks/nightmares
□Hearing voices/seeing things not there
□Paranoid thoughts/thoughts that someone is watching you, out to get you or hurt you
□Thoughts of running away
□Perfectionism
□Rituals of counting things, washing hands, checking locks, doors, stove, etc. / overly concerned about germs
□Binge eating/purging
□Excessive exercise
□Job problems
□Other_____

Add details for any checked items:

_____
_____
_____
_____
_____

History of Presenting Problem

Have you received or participated in previous counseling and/or therapy? □Yes □No
Describe your previous treatment experience. □N/A

_____
_____
_____
_____

Have you had hospital stays for psychological concerns □Yes □No
Are you currently experiencing thoughts of harming yourself or someone else? □Yes □No
Have you in the past experienced thoughts of harming yourself or someone else? □Yes □No

Medical History

List any current or important past medications, their dose, and your response to them.

_____
_____
_____
_____
_____

List any history of serious childhood illnesses.

_____
_____
_____
_____
_____

List any other health concerns, serious illnesses, head injuries, seizures, conditions, or major operations requiring hospitalization during your lifetime.

_____
_____
_____
_____
_____

List any allergies.

_____
_____
_____

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, who is your primary care physician, address, and phone number?

_____
_____
_____

Will you give consent to coordinate care with your PCP? □Yes □No

How many caffeinated drinks do you consume each day/week?

_____

Do you use nicotine in any form? □Yes □No Include type and amount below.

_____
_____

Do you have a healthy diet? □Yes □No Give more detail below.

_____
_____

Do you exercise? □Yes □No Give details below.

_____
_____

Family History

Who were you raised by? □Mother □Father □Both Parents □Step-mother □Step-father □Other_____

Rate your relationship with:

Mother: □Good □Fair □Poor □Close □Distant □Other_____

Father: □Good □Fair □Poor □Close □Distant □Other_____

Step-parent: □Good □Fair □Poor □Close □Distant □Other_____

Other: _____ □Good □Fair □Poor □Close □Distant □Other_____

List your siblings and describe your relationship (Good, fair, poor, close, distant, etc.) with them?

Name_____ Age_____ Gender_____ Relationship_____
Name_____ Age_____ Gender_____ Relationship_____
Name_____ Age_____ Gender_____ Relationship_____
Name_____ Age_____ Gender_____ Relationship_____

Do you have a history of neglect, and/or physical, verbal, emotional, or sexual abuse?

_____
_____

Do you have a family history of substance abuse, mental illness, suicide, or violence?

_____

_____

Developmental History

Did you walk, talk, and read on time?

_____

_____

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

_____

_____

Social and Recreational History

Describe your relationship with peers and/or friends?

_____

_____

Describe your hobbies/interests:

_____

_____

Sexual and Relationship History

What is your sexual orientation? _____

What is the date you were married, separated, divorced, or widowed? _____

If you are or were married please briefly describe nature of your marital relationship/separation/divorce:

_____

_____

_____

_____

Please list any previous marriages/significant relationships from age 18 including current name, date, and the nature of the relationship.

_____

_____

_____

Do you have children? □Yes □No

If yes, list each child's name, age, gender, and the nature of the 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, what is the name and number of your caseworker? (They will not be contacted without your consent.)

_____

_____

_____

Spirituality

Do you have any spiritual beliefs that you wish to include in therapy?

_____

_____

Legal and Military History

Do you currently have any pending criminal charges? □Yes □No

Are you on probation? □Yes □No

If yes, what is the name, county, and phone number of your probation officer? (They will not be contacted without your consent.)

_____

_____

If you are on probation, will you give consent for your probation officer? □Yes □No

Have you ever been arrested/convicted of a crime? □Yes □No

If yes, complete this chart:

List any Arrest/Convictions	Date of Arrests/Convictions	Outcome

List any involvement in any legal cases. (Bankruptcy, divorce, lawsuits, etc.)

_____

Have you ever been in the military? □Yes □No

If yes, what branch and rank? □N/A

_____

_____

Any additional Information

_____

Educational History

When attending school where you: □Regular classes □Home Study □Cyber School □Special classes
□Advanced classes □Other

Did you have any problems in school? (Suspension, dropped out, learning disability, etc.)

_____

_____

What is the highest education level you achieved and when did you achieve it?

_____

Any additional education information? (College major, GED, etc.)

_____

_____

Employment 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?

_____

_____

In what fields have you worked?

_____

_____

Complete the following chart if you have ever received treatment for substance abuse. □N/A

Name of Treatment Program	Type of Treatment	Date of Treatment	Outcome

Additional Information

Summarize your goals for counseling/therapy:

_____

_____

Do you have any cultural concerns? If so, what?

_____

_____

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

_____

_____

_____

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Counselor Signature_____ Date_____