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Client Information

Please complete the following questions to the best of your ability. This information is confidential. They are intended to assist us in providing the most informed care.

Client Name_____Age:_____

In your own words briefly describe the main reason you are here for care:_____

_____

What are you hoping that you will accomplish and how long are you expecting to be in therapy/counseling?_____

_____

Family Information:

Spouse/Partner's name:_____If married, for how long?_____

If divorced/separated, for how long?_____ Number of marriages:_____

Describe previous significant relationships (spouse/ partner's name/s, length of relationship, reason for ending):_____
_____

What was your age when you first married?_____How many children do you have?_____
Step or other children in your life:_____

Please list your children's names and ages:_____
_____

Describe any problems your children are having:_____

Do any blood relatives of yours have any mental health or substance abuse problems?_____

Please describe:_____

_____

Health Information

Please provide the name, address and, phone number of your Primary Care Physician (if you have one):

Name:_____ Phone:_____

Address_____

Please list any medical problems or conditions for which you are currently being treated:_____

_____

_____

Height _____ Weight (if applicable) _____

Current Medications (prescription, herbal or over the counter):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

_____
_____
_____
_____
_____
_____

Please list any medications you have taken in the past that were prescribed to alleviate mental health symptoms:

_____

Have you previously received any counseling, psychotherapy or psychiatric care?_____

Please describe (when, what kind, by whom):_____

_____

Have you ever been hospitalized:_____ For what? When?_____

_____

Any history of suicide attempts:_____Describe:_____

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Personal Information

Name three words to describe yourself:_____

Name three words to describe your Father: _____

Name three words to describe your Mother: _____

Name three words to describe your spouse/partner:_____

Name three words to describe the family you grew up in: _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Who lives in your household with you currently (names, ages, relationship)?_____

_____

Briefly describe your level of social support/ friends:_____

_____

Is spirituality important in your life?_____ If so, explain:_____

_____

Please briefly describe any recent significant life events (ie; death in the family, loss of job, recent move, etc) :_____

_____

Have you ever been physically, emotionally, or sexually abused by anyone? Please briefly describe as much as you are comfortable: _____

_____

Please describe any legal issues (for example custody, probation for DUI, assault etc.) you are currently or have previously been involved in: _____

_____

Please describe your usage of alcohol and/or drugs (current or past):
_____

_____

Have you experienced any traumatic events?_____ Describe as much as you feel comfortable:_____

_____

Do you consider yourself to have a healthy relationship with food? _____ Describe:_____

_____

Are you currently in school? ____ If so, where?_____ Major course of study?_____

Current occupation:_____ How long?:_____

Rate your level of employment satisfaction: 1 2 3 4 5 6 7 8 9 10

What diagnosis or condition, if any, that you know about do you think might apply to you?_____

Any additional information you would like to include:

_____

_____

PLEASE CHECK ALL THAT APPLY :

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		

Irritability	Employer	Chest Pain
Concentration	Finances	Lump in the Throat
Headaches	Legal Problems	Sweating
Loss of Memory	Sexual Concerns	Heart Palpitations
Excessive Worry	History of Child Abuse	Muscle Tension
Feeling Manic	History of Sexual Abuse	Pain in joints
Trusting Others	Domestic Violence	Allergies
Communicating with Others	Thoughts of Hurting Someone Else	Often Make Careless Mistakes
Drugs	Hurting Self	Fidget Frequently
Alcohol	Thoughts of Suicide	Speak Without Thinking
Caffeine	Sleeping Too Much	Waiting Your Turn
Frequent Vomiting	Sleeping Too Little	Completing Tasks
Eating Problems	Getting to Sleep	Paying Attention
Severe Weight Gain	Waking Too Early	Easily Distracted by Noises
Severe Weight Loss	Nightmares	Hyperactivity
Blackouts	Head Injury	Chills or Hot Flashes

Other: _____

Which of these is the most significant? _____

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			