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Client History

Welcome. Please fill out the following as completely and legibly as possible and bring to the first appointment. If you are attending therapy with a partner or family member, each person should fill out his or her own forms. This information is confidential.

Client Information Today's Date: ________________________

Full Name: ____

Parent/Guardian Name (if minor): ____

Address: ____

City: ________________________ State: ____________________ Zip: ____________________

Date of birth: ________________________ Age: ______________ Gender: ____________________

Do you identify as transgender or genderqueer? ☐ Yes ☐ No What are your preferred pronouns? ___________

Relationship status:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

☐ Other (specify): ____

Phone: ____ Type: ☐ Home ☐ Cell ☐ Work ☐ Other

May I leave a message at this number? ☐ Yes ☐ No

Email: ____

Where did you hear about my services? ____

Client History, Concerns, and Goals

Describe what has happened recently that led you to seek counseling now:

____

____

____

Describe current concerns and symptoms:

____

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Please check the symptoms that are of concern:

☐ Aggression	☐ Family Problems	☐ Feeling unimportant
☐ Feeling down or depressed	☐ Self-harm	☐ Argumentative
☐ Alcohol dependence	☐ Excessive crying	☐ Wishing to be dead
☐ Anger	☐ Gambling	☐ Repetitive actions
☐ Difficulty sleeping	☐ Racing heart/palpitations	☐ Nightmares
☐ Worrying	☐ Problems with friends	☐ Headaches
☐ Disorganized	☐ Weight changes	☐ Threatening or fighting
☐ Sleeping too much	☐ Perfectionism	☐ Restlessness
☐ Panic attacks	☐ Hallucinations	☐ Sexual issues
☐ Trauma or abuse history	☐ Intense Fears	☐ Difficulty concentrating
☐ Drug dependence	☐ Loneliness	☐ Feelings of guilt
☐ Thoughts of suicide	☐ Hopelessness	☐ Chest pain
☐ Avoiding people	☐ Appetite changes	☐ Obsessions
☐ Avoiding issues	☐ Stomachaches	☐ Memory issues
☐ Easily distracted	☐ Difficulty breathing	☐ Partner difficulties
☐ Eating disorder	☐ Lying	☐ Body image concerns
☐ Anxiety	☐ Impulsiveness	☐ Difficulty at work/school
☐ Unmotivated	☐ Irritability	

Please describe how the above symptoms impair or otherwise affect your ability to function effectively:

____

____

Have there been any recent changes in the following?

☐ Sleep patterns	☐ Eating patterns	☐ Behavior	☐ Energy level
☐ Physical activity level	☐ General disposition	☐ Weight	☐ Nervousness/tension

Describe changes in areas checked above:

____

____

Do you have, or have you ever had, thoughts about hurting yourself or others? ☐ Yes ☐ No

If yes, please explain (when, for how long, constant or intermittent, thoughts, plans, or attempts, etc.):

____

____

What are your goals for therapy?

____

____

____

Have you had previous counseling? ☐ Yes ☐ No
If yes, please explain (when, for how long, location/agency/therapist, etc.):

Have you ever participated in mental health treatment (drug and/alcohol, self-help groups, etc.)? ☐ Yes ☐ No
If yes, please explain:

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No
If yes, please explain (circumstances, when, for how long, location):

Family History
List parents, siblings, and any other significant members in your household while growing up:

Name	**Gender**	**Age**	**Relationship to Client**	**Still living?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

☐ Parents legally married
☐ Parents separated
☐ Parents divorced

☐ Mother remarried: Number of times: ____________
☐ Father remarried: Number of times: ____________

What was it like for you growing up in your family?

Are there any special or traumatic circumstances that affected your development? ☐ Yes ☐ No
If yes, please describe:

Has there been history of child abuse? ☐ Yes ☐ No If yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal

If yes, the abuse was as a: ☐ Victim ☐ Perpetrator

How were your parents as marital/sexual role models? What were their attitudes about touching and privacy?

List current partner, children, and/or others in your household:

Name	**Gender**	**Age**	**Relationship to Client**	**Still living?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What is it like for you in your current living situation?

Describe your current support system (family, friends, organizations):

Has anyone in your family had counseling, been involved in self-help groups, or had suicidal thoughts or attempts? ☐ Yes ☐ No If yes, please explain:

Length of current relationship: ____________________ Quality of current relationship: ☐ Good ☐ Fair ☐ Poor

Number of prior marriages: _________________________ Sexual orientation: ______________________________

Do you have any sexual concerns or issues you might like to discuss? ☐ Yes ☐ No If yes, please explain:

Describe any spiritual or meditative activities that you are involved in:

____

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Medical History

Date of your last physical exam: ____________________

Primary Care Physician: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________

Fax: ____________________

Psychiatrist: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________

Fax: ____________________

Describe your current health including diet, exercise, chronic health problems, etc.:

____

____

____

Do you have any diagnosed medical or physical health issues? ☐ Yes ☐ No If yes, please explain:

____

____

____

Please list major injuries, illnesses, or surgeries:

____

____

____

Are you on any medications? ☐ Yes ☐ No If yes, please list below:

Medication	**Dose**	**Purpose**

Chemical Use History

	How often	**Date of first use**	**Date of most recent use**
Alcohol			
Marijuana			
Cocaine/Crack			
Heroin/Opiates			
PSP/LSD/Psychedelics			
Tobacco (e.g. cigarettes)			
Other			
Other			

Describe when and where you typically use substances:

____

____

____

Describe any changes in your use patterns:

____

____

____

Describe how your use has affected your family or friends (include their perceptions of your use):

____

____

____

How do you believe your use affects your life?

____

____

____

Have you had a DWI/DUI? ☐ Yes ☐ No If yes, how many? ________________

Education and Employment

Highest level of education: ___________________

Current employment and work history (brief summary):

____

____

____

Have you served in the military? ☐ Yes ☐ No

If yes, which branch? ____

When did you serve and for how long? ____

Legal

Are you involved in any legal proceedings? ☐ Yes ☐ No (Worker's comp, custody dispute, DUI, etc.)

If yes, please describe:

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