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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 pronouns do you use? _____

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:

Please check the symptoms that are of concern:

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

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Sleep patterns | <input type="checkbox"/> Eating patterns | <input type="checkbox"/> Behavior | <input type="checkbox"/> Energy level |
| <input type="checkbox"/> Physical activity level | <input type="checkbox"/> General disposition | <input type="checkbox"/> Weight | <input type="checkbox"/> 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?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Medical History

Date of your last physical exam: _____

Primary Care Physician: _____

Psychiatrist: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Phone: _____

Phone: _____

Fax: _____

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:
