

# JEN MCVANN, MS LMFT CST

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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:

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Describe current concerns and symptoms:

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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:

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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:

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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.):

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What are your goals for therapy?

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Have you had previous counseling?  Yes  No

If yes, please explain (when, for how long, location/agency/therapist, etc.):

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

If yes, please explain:

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Have you ever been hospitalized for mental health reasons?  Yes  No

If yes, please explain (circumstances, when, for how long, location):

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### 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?

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Are there any special or traumatic circumstances that affected your development?  Yes  No

If yes, please describe:

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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?

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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?

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

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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:

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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:

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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: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

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

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

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Please list major injuries, illnesses, or surgeries:

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

Medication	Dose	Purpose

**Chemical Use History**

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

Describe when and where you typically use substances:

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Describe any changes in your use patterns:

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

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How do you believe your use affects your life?

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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):

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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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