Client History and Information

Basic Information:

Date:

Patient Name:

Social Security Number:

Date of Birth:

Gender: [ ] Male [ ] Female

Ethnicity:

Religion:

Home Address:

Home Phone Number: May we leave a message? [ ] Yes [ ] No

Work Phone Number: May we leave a message? [ ] Yes [ ] No

Mobile Phone Number: May we leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:

Name of Guardian:

Address of Guardian:

Guardian's Home Phone: _____ May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone: _____ May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone: _____May we leave a message? [ ] Yes [ ] No

Who referred you to our office, or how did your learn about our practice?

In Case of Emergency who she we contact?
Name:
Relationship:
Cell Phone Home Phone Work Phone

History Information

Who is providing the history information?

[ ] The patient [ ] The patient's 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/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.

[ ] Depression/Sad/Down feelings

[ ] High/Low energy level

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Hearing voices/Seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Feelings of being cheated

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting

[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating

[ ] Excessive exercise

[ ] Indecisiveness about career

[ ] Job problems

[ ] Other:

Have you received or participated in previous counseling and/or therapy? Yes No

When/Where/How Long?

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Do you have any medical issues that I should know about?

List any current or important past medications

Medication & Dose: Response to Medication:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time?

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

What are you good at? What are your strengths?

Describe any cultural concerns:

What is the highest educational level you have completed?

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Which best describes your marital status?

If you are married, please briefly describe nature of your marital relationship:

Please list any previous marriages/significant relationships including current: Additional Information

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes

[ ] No

If you answered yes, please complete the substance abuse history chart (Link is on the website)

Summarize your goals for counseling/therapy:

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

_____ _____

Signature of client or guardian Date