



Client's legal name: _____ Date: _____

Preferred name _____

Gender: ___ F ___ M ___ Other Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

Emergency contact name: _____ Phone: _____

If you need more space for any of the following questions, please use the back of this sheet.

Primary reason(s) for seeking services:

- Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive Behaviors Alcohol/Drugs Gender related
 Other mental health concerns (specify): _____

Counseling/Prior Treatment History

Information about **client** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (ex. AA, Al-Anon, NA, Overeaters Anonymous)					

Information about **family/significant others** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					

Hospitalizations					
Involvement with self-help groups (ex. AA, Al-Anon, NA, Overeaters Anonymous)					

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No

If Yes, explain: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last:	
					48 hours (Y/N)	30 days (Y/N)
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

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): _____

Reason(s) for use:
 Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does someone in your family have a problem with drugs or alcohol (past or present)? _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No
 If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? Yes No
 If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes No

If Yes, describe: _____

Family Information						
Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						
Other Parent/caretaker						

Significant others (ex. brothers, sisters, grandparents, step-relatives, half-relatives). Please specify relationship.

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Marital status (more than one answer may apply):

- Single
 Divorce in process
 Length of time: _____
 Unmarried, living together
 Length of time: _____
 Legally married
 Length of time: _____
 Separated
 Length of time: _____
 Divorced
 Length of time: _____
 Widowed
 Length of time: _____
 Annulment
 Length of time: _____
 Total number of marriages: _____
 Polyamorous
 Length of time: _____

Assessment of current relationship (if applicable): Good Fair Poor

Parental information:

- Parents legally married
 Mother remarried: number of times: _____
 Parents have ever been separated
 Father remarried: number of times: _____
 Parents ever divorced

Special circumstances (ex. raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, 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

Other childhood issues: Neglect Inadequate nutrition Other (specify): _____

Comments regarding childhood development: _____

Social Relationships

How do you generally get along with other people (check all that apply)?

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

Any current or history of being a sexual perpetrator? Yes No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? Not Somewhat Moderately Very

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into counseling? Yes No

If Yes, describe: _____

Legal

Current Status:

Are you involved in any active cases (traffic, civil, criminal)? Yes No

If Yes, please describe and indicate the court hearing/trial dates and charges: _____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

Past History:

Traffic violations: ____ Yes ____ No

DWI, DUI, etc.: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No

Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information:

Charges	Date	Where (city)	Results

Education

Years of education: ____

Currently enrolled in school? ____ Yes ____ No

Fill in all that apply:

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

Special circumstances (ex. learning disabilities, gifted): _____

Employment

List job history (begin with most recent job):

Employer	Dates	Title	Reason left	How often miss work?

Currently: ____ Full-Time ____ Part-Time ____ Temp ____ Laid-Off ____ Disabled ____ Retired
____ Social Security ____ Student ____ Other (describe): _____

Military

Military experience? ____ Yes ____ No

Combat experience? ____ Yes ____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge date: _____

Leisure/Recreational

Describe special areas of interest or hobbies (ex. art, reading, crafts, physical fitness, sports, outdoor activities, church activities, walking, diet/health, hunting, fishing, bowling, traveling, etc.):

Activity	How often now?	How often in the past?
Medical/Physical Health		

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | _____ |

List any health concerns: _____

List any recent health or physical changes: _____

Current prescribed medication	Dose	Dates	Purpose	Side Effects

Current over-the-counter medication	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____

Please check if there have 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 in which you marked above: _____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten			
			No	Low	Med	High
Breakfast	___ / week					
Lunch	___ / week					
Dinner	___ / week					
Snack	___ / week					

For Staff Use

Therapist's signature/credentials: _____ Date: _____