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

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:

____

____

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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?

____

____

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:

____

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____

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

____

____

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.:

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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:

____

____

____

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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