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Client's name: _____ Date:_____

Legal Guardian (if minor): _____ Form completed by: _____

Address:_____ City:_____State:_____Zip:_____

Phone (home):_____(work):_____

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

Primary reason(s) for seeking services: _____

_____

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

| | | |
|---|---|---|
| Aggression | Withdrawing | Elevated mood |
| Anxiety | Worthlessness | Gambling |
| Anger | Guilt | Sexual addiction |
| Anti-social Behavior | Excessive worry | Low Libido |
| Alcohol Dependence | Irritability | Mood shifts |
| Avoiding People/social settings | Feeling on edge | Hypersexual |
| Binging/Purging | Restlessness | Impulsivity |
| Restricting food/calorie counting | Phobias/fears | Judgment errors |
| Cyber addiction | Fatigue | Excessive spending |
| Depression | Intrusive thoughts | Sleeping problems |
| Tearful | Obsessions/Compulsions | Hallucinations |
| Hopeless/helplessness | Drug dependence | Paranoia |
| Loneliness | Distractibility | Bizarre Behavior |
| | Hyperactivity | Thoughts disorganized |

| | | |
|---|---|---|
| Panic attack | Dizziness | Racing thoughts |
| Heart palpitations | Disorientation | Relationship stress |
| Chest Pain | Sick often | Work Stress |
| Trembling | Speech problems | Memory impairment |
| Numbness | Suicidal thoughts | Other specify):_____ |

Other mental health concerns (specify):_____
_____

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 or treatment?

1. _____
2. _____
3. _____

Do you feel suicidal at this time? YES / NO If Yes, explain:_____

**FAMILY INFORMATION:**

Does/Has someone in your family have had a problem with depression, anxiety, bipolar, ADHD, suicide or drugs or alcohol? YES/NO If Yes, describe:_____

_____

**Relationship Name Age Living: Yes No_____**

Mother _____

Father _____

Spouse _____

Children _____

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.) _____

**PARENTAL INFORMATION:**

____ Parents legally married ____ Mother remarried: Number of times: _____

____ Parents have ever been separated ____ Father remarried: Number of times: _____

____ Parents ever divorced ____ Parents never married

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

**Marital Status** (more than one answer may apply)

____ Single ____ Divorce d ____ Unmarried, living together

____Married ____ Separated _____ Widowed

Assessment of current relationship (if applicable): ____ Good____ Fair____ Poor

**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 _____Emotional/Mental Other: _____

If Yes, the abuse was as a: ____ Victim _____ Perpetrator _____Witnessed

Other childhood issues: ____ Neglect____ Inadequate nutrition____ Other (please specify):

Comments re: childhood development:_____

Any difficulties with school or learning:_____

**SOCIAL RELATIONSHIPS:**

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive ____ Other (specify):_____

Who is your Social support system:_____

Sexual orientation: _____Comments:_____

Sexual dysfunctions? 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:

_____

**SPIRITUAL/RELIGIOUS:**

How important to you are spiritual matters? ____ None____Little ____Moderate____ Much

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 the counseling? YES /NO

If Yes, describe: _____

**LEGAL:**

**Current History:**

Are you involved in any active cases (traffic, civil, criminal)? YES / NO Yes, please describe and indicate the court and hearing/trial dates and charges:_____

Are you presently on probation or parole? YES / NO If Yes, please describe:_____

**Past History:**

Traffic violations: YES . NO (Multiple speeding tickets, accidents, DUI, etc.)

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 ____ 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 (e.g., learning disabilities, gifted):_____

**EMPLOYMENT:**

Currently: ____FT ____PT ____Temp ____Laid-off ____Disabled ____Retired ____Social Security

____ Student ____LOA _____Other (describe):_____

Begin with most recent job, list job history:

Employer Dates Reason left the job How often miss work?

_____ _____

_____ _____

_____ _____

**MILITARY:**

Military experience? YES / NO Combat experience? YES / NO
When:_____Where:_____

Branch: _____ Discharge date: _____ Type of discharge: _____

DateS enlisted: _____Rank at discharge: _____

**LEISURE/RECREATIONAL:**

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

Activity How often now? How often in the past?

_____

_____

**MEDICAL/PHYSICAL HEALTH H ISTORY**

| | | |
|---|---|---|
| Abdominal Pain | Alcoholism | Asthma |
| Abortion | Anemia | Autoimmune Disorders |
| AIDS | Appendicitis | Bed Wetting |
| Allergies | Arthritis | Bleeding Disorders |

| | | |
|---|---|---|
| Bronchitis | Fibromyalgia | Rheumatic fever |
| Cancer | Frequent Urination | Sexually transmitted diseases |
| Chest Pain | High Blood Pressure | Sexual Problems |
| Chicken Pox | Headaches | Sleeping disorders |
| Chronic Pain | Hearing Problems | Shortness of breath |
| Constipation | Hepatitis | Sore throat |
| Crohn's Disease | Kidney Problems | Scarlet fever |
| Colds/Cough | Learning Disorders | Sinusitis |
| Dental Problems | Measles/Mumps | Smallpox |
| Diabetes | Menstrual Pain | Stroke |
| Diarrhea | Miscarriages | Tonsillitis |
| Dizziness | Mononucleosis | Tuberculosis |
| Drug Abuse | Nausea | Thyroid problems |
| Eating problems | Neurological Disorders | Vision problems |
| Ear Infections | Nose bleeds | Vomiting |
| Epilepsy | Obesity | Whooping cough |
| Fainting | PMS | Other:_____ |
| Fatigue | Pneumonia | _____ |

List any other current health concerns: _____

List any recent health or physical changes:_____

**Current prescribed medications Dose Dates started Purpose Side effects**

_____

_____

**Past History of Psychiatric Medications: (Include dose, dates used, purpose for use, side effects)**

_____

_____

_____

_____

**Current OTC medications or supplements: Dose Dates started Purpose Side effects**

_____

_____

Are you allergic to any medications or drugs? YES / NO If Yes, describe:_____

Primary Care Physician: _____Last physical exam:_____

Abnormal Lab results: _____

Therapist/counselor: _____ Ph #: _____

Previous Psychiatric Prescriber: _____

Surgery History _____

Family history of medical problems:_____

**NUTRITION:**

**Height:_____ Weight: _____ Recent Wt loss or gain: _____**

**Meal ____ How often Typical foods eaten**

Breakfast ___ /week _____

Lunch ___ /week _____

Dinner ___ /week _____

Snacks ___ /week _____

Comments: _____

Past/present issues with binging, purging, use of laxatives? YES / NO _____

**CHEMICAL USE HISTORY:**

| **Method/Amount used** | | **Frequency of use** | **Age of first use** | **Used in last 30 days** | **Used in last 48 hours** |
|---|---|---|---|---|---|
| Alcohol | YES / NO | | | | |
| Barbiturates | YES / NO | | | | |
| Benzodiazepines | YES / NO | | | | |
| Cocaine/Crack | YES / NO | | | | |

Heroine/Opiates YES / NO _____

Marijuana YES / NO _____

Methamphetamines YES / NO _____

Hallucinogenics YES / NO _____

Caffeine YES / NO _____

Nicotine YES / NO _____

Over the counter YES / NO _____

Prescription drugs YES / NO _____

Other drugs _____

Substance of preference: 1. _____ 2. _____3. _____

Describe when and where you typically use substances:_____

Describe any changes in your use patterns:_____

Describe how your use has affected your family, friends or work: _____

_____

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

Reason(s) for use: ___ Addicted ___Build confidence ___Escape ___Self-medication
___ Socialization ___ Taste ___ Other (specify): _____

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

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? YES / NO

If Yes, describe:_____

**COUNSELING/PRIOR TREATMENT HISTORY**

Counseling/psychiatric: _____

Suicide thoughts/attempts: _____

Drug/alcohol treatment:_____

Hospitalizations: _____

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous): _____