CLIENT INFORMATION AND HISTORY

Name: ____ Date: _______________________

Birthdate: ______________ Age: ______ Gender Identity: __________ Sexual Orientation: _________________

Address: ____

City:____________________________________ State: ___________ Zip: _______________

May I send correspondence, such as billing statements, to this address? ______________________

Primary phone: _______________________________________ May I leave a message? _____________

Secondary phone: ____________________________________ May I leave a message? ______________

Email: ____ May I contact you via email? _____

EMERGENCY CONTACT Name: ___________________________________ Relationship: ________________

EMERGENCY CONTACT Phone number: ____

OCCUPATION INFORMATION:

Occupation: ____ Part-time _____ Full-time_____

Employer(s): ____

Student? ______ Full or part time?_________ School:____

Retired? ______ Laid-off? ______ Full-time parent or care giver? _______ Other?___________________________

Have you served in the armed services? __________________ If yes, what branch? __________________________

And when did you serve? ____

CURRENT SITUATION:

What brings you to counseling at this time? ____

____

____

____

What efforts have you made toward resolving this already? ____

____

What changes are you hoping to experience as a result of counseling? ____

____

Are you experiencing any of the following?

_____ Depressed mood _______ Decreased energy/fatigue _____ Anxiety/fear _____ Panic

_____ Tearfulness _____ Thoughts of harming others ____ Thoughts of harming yourself

_____ Loss of interest in activities _____Loss of energy ____ Restlessness _____ Headaches

_____ Muscle tension _____ Weight loss/gain _____ Changes in sexual behavior

_____ Difficulty concentrating _____ Loss or increase in appetite _____ Change in alcohol/drug use

_____ Grief _____ Irritability _____ Angry outbursts

_____ Guilt _____ Decreased or poor sleep _____ increased sleep

_____ Feelings of worthlessness _____ Physical or sexual abuse ______ Hallucinations/hearing voices

Are you currently having suicidal thoughts? _____ Have you ever deliberately harmed yourself? _____

Are you currently in the care of a psychiatrist? _____ If so, whom? ____________________________

HISTORY

Have you experienced physical abuse? ___________ Sexual abuse? ____________ Emotional abuse?__________

Do you have a history of other emotional or physical trauma? ____

____

Do you gamble? ____

If yes: Have you ever had to lie to people important to you about how much you gambled? _____________

Have you ever felt the need to bet more and more money? _________________________________

Have you had previous counseling or psychiatric treatment? If so, when and with what provider? _______________

____

If you had previous counseling experience, what was it like for you? ______________________________________

____

Have you ever been diagnosed with an emotional or mental disorder? ________ If so, what was the diagnosis?

____

MEDICAL INFORMATION:

Please list current medical conditions, if any: ____

____

Allergies/sensitivities: ____

Please list any current medications (prescription, over the counter, supplements, etc.): ________________________

____

SUBSTANCE USE INFORMATION:

Do you smoke/chew tobacco products? ________________ How much per day? _________________________

Do you drink alcohol? _______ How often? _______________ How many drinks per occasion? ____________

Other substance use:

Substance	How often?	How much at a time?	Age of first use?	Date of last use?
_________________	_____________	__________________	_____________	_____________
_________________	_____________	__________________	_____________	_____________
_________________	_____________	__________________	_____________	_____________

Have you ever used more of a substance than you intended?___________________________________

Have you ever had difficulty reducing your use of any substance? _______________________________

Has drinking alcohol or using other substances caused problems for you with any of the following?

____Family ____ Friends _____ Significant Other _____ Children ____ Work

____ School _____Legal _____ Health _____ Financial

LEGAL HISTORY

Are you involved in any active legal issues (if yes please describe)? ______________________________________

____

Have you ever been arrested? _____ If so, when and what was the charge? _______________________________

Are you currently on probation? ____

HOUSEHOLD/FAMILY MEMBERS:

Name	Age	Relationship
______________________________	__________	____________________________________
______________________________	__________	____________________________________
______________________________	__________	____________________________________
______________________________	__________	____________________________________

_______________________________ __________ ____________________________________

FAMILY HISTORY:

Has anyone in your family ever been :

_____ Depressed	_____ Highly anxious	_____ Mentally or emotionally ill
_____ A heavy drinker	_____ A substance abuser	_____ Violent
_____ Suicidal	_____ Physically abusive	_____ Sexually abusive
_____ Chronically ill	_____ Moody	_____ Frequently angry/irritable

Is there anything else you would like to share about your family history? ___________________________________

____

SUPPORT SYSTEMS:

Please list friends and family members who are supportive of you: ____

____

Please list groups, activities or other sources of support: ____

____

Please list some of your personal strengths and/or positive attributes: ______________________________________

____

____
Printed Client Name

____ __________________________
Signature of Client Date