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Client Information, History, Concerns and Goals

Name: _____ Date_____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell:_____

Email address: _____

Birth date: _____ Age: _____ Education: _____

Religious preference: _____ Race Culture: _____

Client Referred by: _____

Marital Status: _____ Name of Spouse: _____ Age of Spouse: _____

Date of marriage:_____ Prior Marriages/Dates: _____

Children

Name	Age	Living at Home?

Family of origin (mother, father, sisters, brothers). Please include yourself and list in order of age.

Name	Age	Occupation	Relationship	Living at Home (Yes or No)	Alive or Deceased

Person through whom you can always be reached (relative or close friend):

Name: _____ Phone: _____

Address: _____

Employer Name: _____

Employer Address: _____

Occupation: _____

Work History: (Past 5 years)

Employer	Occupation	Dates of Employment	Reason for leaving

Name and Type of Insurance Carried: _____

Family Doctor: _____ Phone: _____

Date of last visit to medical doctor: _____ Date of last physical exam: _____

Please fill in the following information as completely as possible.

1. Describe what has happened recently that led you to seek counseling now. _____

2. Describe current concerns and symptoms. _____

3. Check the one response which best applies:

(A)	My current concerns and symptoms are:	(B)	My current symptoms developed:
□	The continuation of a long-standing condition	□	Suddenly (less than four weeks)
□	A recent worsening of an on-going condition	□	Gradually (one to several months)
□	The reoccurrence of a previous condition	□	Very gradually (one to several years)
□	Significantly different from any previous condition		
□	My first occurrence of any condition		

4. Your medical history: please list any major injuries, illnesses or surgeries.

Condition Dates Treatment

5. Are you currently on any medication? Yes □ No □

Medication Dosage Prescribing Physician Date Started

Please list any medications you are allergic or sensitive to:

6. Are there any psychiatric medications you have taken in the past (and are not currently taking)?

Medication Dosage Prescribing Physician Date Started

7. Please indicate any significant prenatal events and developmental history for yourself.

8. Please list any other substances that you use and include their amount and frequency.

Alcohol _____	Heroin _____
Marijuana _____	Psychedelics _____
Caffeine _____	Methamphetamine _____
Tobacco (cigarettes, etc.)_____	Other _____
_____	_____

9. Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapies and hospitalizations, dates and reason for treatment.)

_____

_____

_____

10. Describe your relationship with your family of origin. Include parental substance abuse issues as well as other relevant life events. _____

_____

_____

_____

_____

11. Has anyone in your immediate or extended family had a psychiatric illness? Please list their relation with you and the nature of their illness. _____

_____

_____

_____

12. Did you have thoughts about hurting yourself or others? Yes □ No □ If so, please describe. _____

_____

_____

_____

13. Please describe your current family situation. _____

14. Briefly describe your current support system (family, friends, organizations, etc.)

15. Briefly describe your strengths and weaknesses. _____

16. Please describe your goals for therapy. _____