Client Name: ______________________ DOB: __________ Sex: _______ Date Completed: ______
Name of person Completing this form and relationship to client: ________________________________

Reason for seeking counseling:

Problems and Symptoms	**Past**	**Present**	**Not Applicable**	**Explanation**
Change of Appetite				
Bingeing/purging food				
Weight loss/gain				
Insomnia/hypersomnia				
Withdrawn				
Depression				
Mood Swings				
Anxiety				
Obsessive Thoughts				
Compulsive Behaviors				
Anger Management				
Cruelty to Animals				
Poor Memory				
Processing Difficulty				
Fire setting				
Bladder Control				
Bowel Control				
Aggression				
Lying				
Stealing				
Sexual Acting Out				
Sexual Dysfunction				
Nightmares/night terrors				
Vivid dreams				
Fears				
Unexplained physical complaints				
Abuse/neglect				
Grief/loss				
Stress				
Flash Backs				
Financial				
Addictive Behavior				
Impulsivity				
Hyperactivity				
Lethargic				
Poor Concentration				
Short Attention Span				
Poor Family Relations				
Poor Relations in the Workplace				
Poor Relations with Peers				
Hallucinations/delusions				
Difficulty with Authority				
Spiritual Issues				
Feeling inadequate/Low self worth				
Other				

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Mental Health History: (Past out patient services and hospitalizations, include dates)
____
____
How did it help? ____
What was your diagnosis(es)? ____
Have you ever experienced suicidal/homicidal ideations? Yes/No Intentions? Yes/No
If yes, please explain: ____
____
Are you willing to sign a release of information for previous mental health providers? Yes/No

Significant Relationships (Circle One): Married Divorced Widowed Significant Other….Single
If married/divorced how many times? _________ How long married/divorced? _________
Name children and ages: ____
On a scale of 1-10, 10 being very satisfied, rate level of satisfaction with current relationship: ________

Legal Issues: (List any past & present legal issues: i.e., arrests, convictions, bankruptcy, divorce etc. include dates) ____
____

Abuse History (has client been victim of any type of abuse?)**:**

Physical abuse	☐ Yes ☐ No	Emotional Abuse	☐ Yes ☐ No	Sexual Abuse	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No	Abandonment	☐ Yes ☐ No	Neglect	☐ Yes ☐ No

Age(s) at time of abuse: _____________________ Treatment received: ____________________
Who was perpetrator? ____
Reported to Authorities? ____________________ Finding/disposition: ____________________

Did client witness any types of abuse listed above: ☐ Yes ☐ No
If yes, which type of abuse? ____
Who was the victim? ____________________________ Who was the perpetrator? __________
Has client been the perpetrator of any abuse? ☐ Yes ☐ No Who was the victim? ____________
If yes, which type of abuse?

Addiction/Substance Use History (If you need more space use back of page)**:**

Substance	Yes	No	Substance	Yes	No	Substance	Yes	No
Alcohol			Pain Pills			Marijuana		
Tranquilizers			Stimulants			Inhalants		
Sleeping Pills			Narcotics			Food		
Hallucinogens			Heroin/Meth			Sex		
Gambling			Pornography			Other		

Drug of preference: ___________ How long used? __________ Last used? _____________
Treatment program: __________ When? ________ How long? ________ How long clean/sober? ______

Medical History (If you need more space use back of page)**:**
List any major accidents, illnesses, operations with date of occurrence: ___________________________
____
____
List date and type of any head injuries or seizures: ______________________________________
____
List current medications and reason prescribed: ____
____
List any allergies to medications: ____
List any sexually transmitted diseases: ____

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Physician:
Are you currently under a physician's care? ____
Names of Physicians/Specialists who are treating you: ______________________________
____
____
____

Education:
Highest grade completed: __________________ Graduated/degree: ____________________
Any difficulty learning to Read: ______ Write: _______ Math: _________
Did you ever repeat a grade? Yes/No For what reason: ____________________________
Favorite subject: ______________________ Most accomplished subject: _______________
Circle One:
I learn best by: seeing it done reading about it hearing about it

Occupation:
Current occupation/vocation: ______________________ How long: ___________________

On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? ______
Please describe any difficulties you are having concerning your occupation: __________________
____
____

Social Relationships:
How frequently do you socialize with friends? ____________________________________
How frequently do you socialize with extended family? ______________________________
What kinds of activities do you do when you get together? ___________________________
____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: _____
Rate your satisfaction with extended family relationships: ______
Who do you feel is "on your side" in life? _______________________________________
Are there any people in your life you can talk to about your problems? ___________________
Please describe any difficulties you are having socially: ____________________________
____

Family History (Please list those family members with a <u>history of mental illness, learning disabilities, mental retardation or addictions</u>) (If you need more space use back of page)
Children: ____
____
Parents: ____
____
Siblings: ____
____
____
Maternal Grandparents: ____
____
Paternal Grandparents: ____
____
Maternal Aunts and Uncles: ____
____
Paternal Aunts and Uncles: ____
____

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Developmental History:
Prenatal health issues: ____
____
Birth Trauma (C-section, birth injuries, complications): ____________________
____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding: ____
Motor skills: ____
Toileting: ____
Speech/language: ____
Social Skills: ____
Temperament: ____

Sexual History:
Age at first sexual experience? ____________________________________
On a scale of 1-10, 10 being very satisfied, how would you rate your sexual experiences: ________
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your sexual self-image: ______
On a scale of 1-10, 10 being very satisfied, how satisfied are you with the frequency of sex: _______
Please describe any sexual difficulties you are having: __________________________
____
____

Nutrition:
How many ½ cup servings of fresh fruits and vegetables do you eat daily? ____________
How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)__________
How much tobacco do you smoke/chew daily? ______________________________
How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None
How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None
Energy level: lethargic low average high hyperactive
How would you rate your current health: poor fair good excellent
List any food allergies you have: ________________________________
How would you rate your weight/height/body fat ratio: poor fair good excellent
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image
Please describe any difficulties you are having with health, nutrition, body image: __________
____
____
Describe your exercise routine (what you do, how often you do it) ____________________
____
____

Spiritual History:
Do you believe in God? Yes/No
Do you have a religious affiliation with which you are active? Yes/No
Do you use any particular religious writings (Bible, Tanakh, Qur'an etc) to find truth for your life? Yes/No
How does your faith help you to cope with life's problems? ____________________
____
____
____
Please describe any difficulties you are having concerning your faith ________________
____
____

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Goals for Counseling:

What three things would you like to change by participating in counseling?
1. ____________________
2. ____________________
3. ____________________

How long do you think it will take to make these changes? ____________________

What do you think it will require on your part to make these changes? ____________________

How will you know when you have accomplished your goals for counseling? ____________________

What else do you think is important for your counselor to know about you? ____________________

Emergency Contact:
Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)

____

Client Signature: ____________________ Date: __________

Primary Caregiver's signature: ____________________ Date __________

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