Client History and Information

Basic Information:

Patient Name: ____Date of assessment: ________________
Date of Birth: ________________________ Age: ___________Gender: [ ] Male [ ] Female [ ] Transitioning
Ethnicity/Cultural affiliations: ____
Sexual orientation: ________________________________ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Place of birth:__________________ Primary language: ________________Religious affiliation:________________
Mailing Address: _______________________________City, State, Zip:___________________________________
Home Phone Number: _____________________ May we leave a message? [ ] Yes [ ] No
Work Phone Number: _____________________ May we leave a message? [ ] Yes [ ] No
Mobile Phone Number: _____________________ May we leave a message? [ ] Yes [ ] No
Email:____

Emergency Contact Information:

In case of an emergency, who should we contact? Name: ____
Relationship: ______________________________ Phone Number: ____
Address: _________________________________City, State, Zip:____

If the above patient is a minor complete the following:

Name of Guardian: ____
Address: _________________________________City, State, Zip:____
Guardian's Home Phone: _____________________May we leave a message? [ ] Yes [ ] No
Guardian's Work Phone: _____________________May we leave a message? [ ] Yes [ ] No
Guardian's Mobile Phone: ____________________May we leave a message? [ ] Yes [ ] No

Insurance Information:

If you will be using insurance to cover your sessions in full or in part, please complete the following. We will need to photocopy your insurance card(s) & photo ID: Primary Insurance Company: ________________________________
Name of Sponsor:_________________________ Sponsor ID#: ______________________Sponsor DOB:_________
SS#______________________ Group#_______________(if applicable)

Secondary Insurance Company: ________________________________
Name of Sponsor:_________________________ Sponsor ID#: ______________________Sponsor DOB:_________
SS#______________________ Group#_______________(if applicable)

Referral Source

Who referred you to our office, or how did you learn about our practice? ___________________________________

History Information

Who is providing the history information?
[ ] The patient [ ] The patient's guardian [ ] Other
Please describe the current complaint or problem as specifically as you can, in your own words.
____
____

How long have you experienced this problem, or when did you first notice it?

____

____

What stressors may have contributed to the current complaint or problem?

____

____

Check all words/phrases that describe what you are experiencing and explain if possible:

[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Indecisiveness about career

[ ] Marital Discord
[ ] Self-harm/Cutting/Burning self
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tensions, aches, etc.
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Job problems

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated
[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise

[ ] Other:

Previous Treatment

Are you currently seeing a psychiatrist: [ ] Yes [ ] No. If yes who and when was your last visit:

____

What was the outcome of your psychiatric visit? (medications and dosages, referral to therapy, diagnoses):

____

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No
What did you like/dislike about previous treatment?

____

____

What did you learn about yourself through previous counseling/treatment that may help you?

____

____

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Is there any type of treatment you would like to continue?
____
____
Have you had hospital stays for psychological concerns? [ ] Yes [ ] No If yes explain(reason, dates, how long):
____

Risk Assessment:

Are you currently experiencing thoughts of harming either yourself or someone else?[ ] Yes [ ] No
Have you in the past experienced thoughts of harming either yourself or someone else? [ ] Yes [ ] No
If Yes, Date of last attempt: ___________ Method:_____________________
Please explain in detail: ____

Developmental History:

Are you aware of any difficulties or complications during the time your mother was pregnant with you?
[ ] Yes [ ] No If yes, explain: ____
Did you walk, talk, and read on time? [ ] Yes [ ] No If no, explain:____________________________________
Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? [ ] Yes [ ] No
Are you satisfied at where you are in your life? [ ] Yes [ ] No
If not, where would you like to be? ____

Medical History:

What was the date of your last physical or routine health "check up?"_____________________
Do you have a primary care physician? [ ] Yes [ ] No If yes, complete the following:
Name: ____
Address: ____ Phone Number: ________________________

List any current or important past medications

Medication Dosage Reason for medication
____
____
____
____

History of serious childhood illnesses:____
Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: [ ]Yes [ ] No
Have you experienced any head injuries? [ ] Yes [ ] No If yes, did you lose consciousness? [ ] Yes [ ] No
Have you experienced convulsions or seizures? [ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No
Explain any allergies you have: ____
How would you rate your current physical health?
[ ] Excellent [ ] Fair [ ] Very Poor
[ ] Good [ ] Poor

Family History

Birth Location: _______________ Raised by: [ ] Mother [ ] Father [ ] Grandparent [ ] Other

Relationship with parent figures:(good, fair, poor, close, distant, etc.)

Mother: ____

Father: ____

Step-parent/Grandparent: ____

Other: ____

List your siblings and describe your relationship with them:

Name	Age	Nature of relationship (close, neutral, estranged)

List any children and describe your relationship with them:

Name	Age	Nature of relationship (close, neutral, estranged)

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? [ ]Yes [ ]No

If yes explain: ____

Any family history of [ ]substance abuse [ ]mental illness [ ]suicide [ ]violence [ ]None

If yes, please explain: ____

Social History

Describe your relationship with peers and/or friends?

____

How would you describe your social support network?

____

Describe your hobbies/interests:

____

Describe any cultural concerns:

____

Educational History

When attending school where you:

[ ] In regular classes [ ] Special classes [ ] Ever suspended

[ ] Home Study [ ] Advanced classes [ ] Placed in alternative school

What is the highest educational level you have completed?_____________________________

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

____

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Occupational History

What is your current employment status?

[ ] Employed Full-Time   [ ] Unemployed   [ ] Student
[ ] Employed Part-time   [ ] Self-employed   [ ] Other

Are you satisfied with your employment? [ ] Yes [ ] No If not, why?
____

Marital History

Which best describes your marital status?

[ ] Married, Date: ______   [ ] Widowed, Date: _____   [ ] Divorced, Date:_______
[ ] Never Married   [ ] Separated, Date: _____

If you are married, please briefly describe nature of your marital relationship:
[ ] Poor [ ] Fair [ ] Good [ ] Great

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No
Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No
If yes please complete the following:
Case Worker's Name: ______________________________Phone:_______________________________

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Tobacco						
Alcohol						
Marijuana						
Opioids/ Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Others:						

Past treatment for drug/alcohol use: (Name & Length)____
Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone): ____
Date of Treatment (Month, Year): ____
Outcome (Any Clean time?): ____

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No
Are you on probation?[ ] Yes [ ] No
Name of Probation Officer and County: ____
Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No: If yes, complete chart.
List any Arrests/Convictions: ____
Date of Arrests/Convictions: ____
Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.): ____________________

Additional Information

Are there any cultural beliefs that would stop you from getting the mental health care you may need?
____
Are there any cultural customs and beliefs that you would like to integrate into your therapy?
____
Summarize your goals for counseling/therapy:
____
What expectations do you have for counseling/therapy?
____
Name 5 things you would like to change about yourself:
____
____

Your strengths (circle all that apply)

Optimistic	Hopeful	Faithful	Empathetic	Caring	Resourceful	Flexible	Independent
Funny	Insightful	Responsive	Good communicator	Open to change	Goal oriented	Compassionate	Family Oriented
Empowered	Hard working	Positive	Planner	Honest	Ambitious	Detail Oriented	Wise
Spontaneous	Friendly	Humble	Forgiving	Loyal	Resilient	Active	Other:

What are your weaknesses?____
Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible?
____
____

___________________________ ___________________________ ____________________
Signature of client or guardian Print Name Date

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