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Client Information and General History

PLEASE FILL IN THIS FORM AS APPLICABLE OR PREFERRED BY YOU

Today's Date_____ Date of Birth ____/____/____ Age_____ F_____ M _____

Last Name_____ First Name _____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____

Name of Spouse/Partner_____ Phone_____

Address_____City_____State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____

Person Responsible for Payment _____

EMERGENCY CONTACT:

Name_____ Relationship_____

Phone Numbers _____

Address_____ City_____ State_____ Zip_____

Primary Care Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Alternative Providers (Chiropractor, Naturopath, Homeopathic Counselor, Nutritionist, etc.)

Name_____ Specialty_____ Phone_____

Address_____ City_____ State_____ Zip_____

Name_____ Specialty_____ Phone_____

Address_____ City_____ State_____ Zip_____

REFERRAL SOURCE

How did you hear of my practice? _____

Address_____ City_____ State_____ Zip_____

Phone_____ Relationship to referral source_____

Primary reason for seeking counseling at this time:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please rate your distress level in these areas according to this scale:

0	1	2	3	4	5
None	A Little	Quite a Bit	Considerable	High	Extreme

_____Sadness
_____Suicidal thoughts
_____Anxiety
_____Panic attacks
_____Sleep problems
_____Eating problems
_____Feeling less social
_____Stress issues
_____Health problems
_____Job related problems
_____Financial concerns
_____Low self-esteem
_____Family conflict
_____Parent-child conflict
_____Marital/relationship problems
_____Sexual concerns
_____Death of a loved one
_____Divorce

_____Physical Abuse
_____Verbal/Emotional Abuse
_____Sexual Abuse
_____Alcohol use (self)
_____Drug use (self)
_____Physical threats/harm to others
_____Legal problems (arrests, probation)
_____Compulsive gambling
_____Brother/sister problems
_____Step-family issues
_____Alcohol/drug use by family member(s)
_____Career concerns
_____Other
_____

Previous or Current Psychiatric Treatment or Counseling:
Approximate year Duration Reasons - Issues at that time

Any history of self-harm or suicide attempts? Yes ____ No ____ If yes, please describe any circumstances and approximate date:

Alcohol Use: (type)_____(amount)_____(frequency)_____

(when?) _____

Drug Use: (type) _____(amount)_____(frequency)_____

(when?) _____

Medical History:

Please list any serious/chronic illnesses or surgeries (previous/current):

Date of last physical exam and results: _____

Current Medications and dosage: _____

Family history of Alcohol/Drug Abuse:_____

Current Relationship Status**:** ___married ___engaged ___committed ___divorced ___single

Current/most Recent Significant Other's First Name:_____

Children's First Names:

_____ Age:_____

_____ Age:_____

_____ Age:_____

Previous Marriages or Significant Relationships**:**

Name: _____ Time together:_____ Ended:_____

Children's Names:

_____ Age:_____

_____ Age:_____

_____ Age:_____

Name: _____ Time together:_____ Ended:_____

Children's Names:

_____ Age:_____

_____ Age:_____

_____ Age:_____

Any other important information you think I should know: _____

_____

_____

_____

_____