

# Alliance Counseling & Coaching of Illinois

Channahon – Joliet – Morris – Ottawa

## HISTORY FOR THERAPY ASSESSMENT

### IDENTIFYING INFORMATION:

#### Client:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security Number: \_\_\_\_\_

#### Insurance Policy Holder:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

#### Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_

Do we have your consent to leave messages on voicemail (Circle Preference) Home Cell

If no please indicate no \_\_\_\_\_

How did you hear about Alliance Counseling & Coaching?

Internet Phone book Doctor Friend Other: \_\_\_\_\_

**SYMPTOMS/LIFE ISSUES:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Depressed          | <input type="checkbox"/> Feel panicky         | <input type="checkbox"/> Sexual Problems     |
| <input type="checkbox"/> Hands shake       | <input type="checkbox"/> Tiredness          | <input type="checkbox"/> Shy                  | <input type="checkbox"/> Home conditions bad |
| <input type="checkbox"/> Vision problems   | <input type="checkbox"/> Can't relax        | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Can't keep job      |
| <input type="checkbox"/> Bowel disturbance | <input type="checkbox"/> Can't sleep        | <input type="checkbox"/> Feel Tense           | <input type="checkbox"/> Financial problems  |
| <input type="checkbox"/> Stomach trouble   | <input type="checkbox"/> Fainting spells    | <input type="checkbox"/> Unusual Feelings     | <input type="checkbox"/> Alcoholism          |
| <input type="checkbox"/> Fast Heartbeat    | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Overambitious        | <input type="checkbox"/> Drugs               |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Feel inferior      | <input type="checkbox"/> Lonely               | <input type="checkbox"/> In-law problem      |

Do any of the following describe you:

- |                        |              |               |                 |
|------------------------|--------------|---------------|-----------------|
| Specific fears         | Tremors      | Panic attacks | Lightheadedness |
| Obsessions/Compulsions | Doom         | Agoraphobia   | Numbness        |
| Anxiety                | Palpitations | Nervousness   |                 |

If yes, describe how: \_\_\_\_\_

**Presenting issue for counseling:** \_\_\_\_\_

**PREVIOUS MENTAL HEALTH TREATMENT:**

Therapist	Location	Dates	Outcome

**PSYCHIATRIC HOSPITALIZATION? (List All)**

Psychiatric Hospital	Date	Reason for Admission	Length of Stay

**Suicidal thoughts:** Past? Present? Explain: \_\_\_\_\_

**Suicidal attempts:** Method Used? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ How was it stopped? \_\_\_\_\_

Hospitalization? \_\_\_\_\_

Please Explain: \_\_\_\_\_

**CURRENT PSYCHIATRIC MEDICATIONS:**

Name	Type/Purpose	Dosage Taken	Frequency Taken


History of mental illness in family Yes No If Yes, describe: \_\_\_\_\_

**CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:**

(ie. Allergies, seizures, high blood pressure, diabetes, cardiac problems TB, etc) \_\_\_\_\_

Name of Medical

Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Psychiatrist \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Where: \_\_\_\_\_ Doctor: \_\_\_\_\_

**CURRENT MEDICATIONS, VITAMINS, & OVER THE COUNTER:**

Name	Purpose	Dosage Taken	Frequency Taken	Prescribed by

Health Behavior (Be specific, No. of ounces, etc.):

Nicotine \_\_\_\_\_ Caffeine \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_

Liquor \_\_\_\_\_ Marijuana \_\_\_\_\_ Speed/Downers \_\_\_\_\_ Other drugs \_\_\_\_\_

Prescription medications: \_\_\_\_\_

**Nutrition**  Poor  Adequate  Excellent If poor, please explain \_\_\_\_\_

**Exercise**  Poor  Adequate  Excellent If poor, please explain \_\_\_\_\_

**FAMILY DATA:**

FAMILY OF ORIGIN:

	Name	Birth date	Age	Sex	Living or Dead	Marital

							<i>Status</i>
<b>SPOUSE</b>							
<b>CHILDREN</b>							
<b>FATHER</b>							
<b>MOTHER</b>							
<b>BROTHERS and/or SISTERS</b>							
<b>OTHERS: (Stepbrother &amp; Sisters, Ex-Spouse, etc.)</b>							

**Describe each parent in three words (indicate if step-parent):**

Mother \_\_\_\_\_

Father \_\_\_\_\_

Which parent are you closest to? \_\_\_\_\_

Describe relationship with parents. Past/Current \_\_\_\_\_

Describe parents relationship to each other \_\_\_\_\_

What is your birth order? \_\_\_\_\_

Describe past/current relationship with siblings \_\_\_\_\_

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Any history of physical/sexual/emotional abuse? Yes No Describe: \_\_\_\_\_

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Did you have a best friend as a child? \_\_\_\_\_

Describe friends as an adult: \_\_\_\_\_

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Describe significant life events: \_\_\_\_\_

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Have you lost someone through death? \_\_\_\_\_

How did you handle situation? \_\_\_\_\_

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**Sexual History:**

Describe your parents attitudes towards sex: \_\_\_\_\_

How did you learn about sex: \_\_\_\_\_

Any frightening or unpleasant sexual experiences? \_\_\_\_\_

Any abuse or trauma? \_\_\_\_\_

If applicable: Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

(Number of each)

**Work History:**

Are you currently employed? \_\_\_\_\_ If so where? \_\_\_\_\_

Type of work or career? \_\_\_\_\_

If employed, do you like your job? \_\_\_\_\_

**Marital History:**

Number of Marriages: \_\_\_\_\_ Date(s) \_\_\_\_\_

Does your marriage need improvement? \_\_\_\_\_

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Concerns you have regarding your marriage: \_\_\_\_\_

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Describe your relationship with your children: \_\_\_\_\_

Concerns you have regarding your children: \_\_\_\_\_

If single, attitude towards single status: \_\_\_\_\_

**Religion**

Describe how your religious beliefs influence your life: \_\_\_\_\_

**Education**

Current/highest grade obtained \_\_\_\_\_

**Legal**

Any current legal problems? (ie, court order, probation/parole, guardianships, arrest, order of protection): \_\_\_\_\_

**Please list your strengths:**

**Anything else you feel your counselor should know about you?**