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Client History

Each person seeking therapy, including each family member or partner, should fill out their own copy.

Today's Date___________________________

Full Name____ Date of Birth ________________Age_________

Home Address____
Street City State Zip Code

Home Phone_______________________ Cell Phone______________________ Work Phone_____________________

Email Address____

Calls or Emails will be discreet, but please indicate any preferences and/or restrictions (OK to leave messages and/or send mail or email? Which phone number is best for communicating with you?)
____

Marital/Relationship Status__________________ How long? ____

Current Occupation____________________________ Employer____

Spiritual Affiliation_______________________________________ Education Level_________________________

Any other identifying information that is important to you? ____

Whom may I thank for referring you?____

Contact in case of Emergency:
Full Name____
Home Address____
Street City State Zip Code
Home Phone_______________________ Cell Phone_______________________ Work Phone____________________
Relationship to You____

Medical Care:
Doctor's/Clinic Name____ Phone__________________________
Address____
Street City State Zip Code

If you are under the care of a medical doctor or psychiatrist, would you consider signing a release so that I may contact your doctor(s) to coordinate treatment? ___________Yes ____________No

Relevant medical conditions (history, current condition, changes in condition) __________________________
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Current medications

Name and Dosage of Medication(s):	Prescribed by Whom?	For What?

Previous Treatment

Have you ever received counseling/therapy services such as: individual, psychological, psychiatric, drug/alcohol treatment, group therapy, or couples therapy?

_______ Yes _______ No if yes, please indicate:

When?	From Whom?	For What?	Describe Results

Have you ever taken medications for psychiatric or emotional issues?

_______Yes _______ No if yes, please indicate:

Name of Medication/Dose	Approx. Dates You Took This Medication (From/To)	Prescribed by Whom?	For What?	Describe Results

Have you experienced any psychiatric hospitalizations or previous suicide attempts?

______ Yes ______ No if yes, please indicate:

When?	Why?	For how long?	Describe Results

Do you have thoughts of suicide right now? ____________Yes ____________No

If yes, do you have a plan? _______________Yes _________________No

Have you ever experienced domestic violence, or any type of physical or sexual abuse?

______________Yes __________________No

Do you feel safe in your current living situation? ___________________Yes __________________No

Marital/relationship history

	Spouse/Partner's Name	Spouse/Partner's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First					
Second					
Third					

Children

Name	Age	Sex	Grade	Adjustment Problems?	From previous relationship? Adopted? Foster?	Lives with you? Y/N

Family of Origin History

Does anyone in your family of origin and/or biological family have a history of substance abuse or mental illness?

__________________Yes ____________________No if yes, please indicate:

Family Member	Relationship to You	How old were you?	Briefly Describe Illness	For how long?	Any treatment?	Describe Result

Support network

Please list any friends, family members, and/or organizations that are important to you; to whom, and where you can turn to for emotional, psychological or spiritual support:

____

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Please check any that apply (one or more times in the past week):

- o Headaches
- o Dizziness
- o Stomach trouble
- o Weight change
- o Bowel trouble
- o Choking feeling
- o Blurred Vision
- o Always tired
- o Muscular aches
- o Hearing voices
- o Trouble sleeping
- o Loss/increase of appetite
- o Feeling tense
- o Binge eating
- o Problems with anger
- o Worried about alcohol/drugs
- o Restricting food
- o Nightmares
- o Unusual thoughts
- o Ready to explode
- o Panicky feeling
- o Tremors or tics
- o Trouble concentrating
- o Nervous around strangers
- o Fear of things one "shouldn't fear"
- o Strange experiences
- o Distrustful of others
- o Conflict with family
- o Thoughts of harming others
- o Self-inflected wounds
- o Lack of motivation
- o Intrusive thoughts
- o Anxiety
- o Flashbacks
- o Excessive checking, lists making, washing
- o Isolating yourself
- o Thoughts of Suicide
- o Can't get interested
- o Can't make friends
- o Can't keep friends
- o Sexual problems
- o Feel like crying
- o Financial problems
- o Feel worthless
- o Trouble with memory
- o Fear of losing control
- o Bad smells others don't smell
- o Can't keep jobs
- o Can't make decisions

Please briefly explain checked items: ____

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Please list what you enjoy doing, your interests, and/or hobbies: ______________________

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Please list your strengths, skills and things you like about yourself: ___________________

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Please list (3) GOALS you have for therapy at this time:

1.____
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2.____
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3.____
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