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	Denied	Explanation
Change of Appetite	☐	☐	☐	
Bingeing/purging food	☐	☐	☐	
Weight loss/gain	☐	☐	☐	
Insomnia/hypersomia	☐	☐	☐	
Withdrawn	☐	☐	☐	
Depression	☐	☐	☐	
Mood Swing	☐	☐	☐	
Anxiety	☐	☐	☐	
Obsessiv ough	☐	☐	☐	
Compu Behaviors	☐	☐	☐	
Anger M ement	☐	☐	☐	
Cruelty mals	☐	☐	☐	
Poor Men	☐	☐	☐	
Processing ficult	☐	☐	☐	
setti	☐	☐	☐	
	☐	☐	☐	
E s	☐	☐	☐	
Aggression	☐	☐	☐	
Lying	☐	☐	☐	
Stealing	☐	☐	☐	
Sexual Acting Out	☐	☐	☐	
Sexual Dysfunction	☐	☐	☐	
Nightmares/night terrors	☐	☐	☐	
Vivid dreams	☐	☐	☐	
Fears	☐	☐	☐	
Somatic 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	☐	☐	☐	

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 His (has client been v of any type of abuse?)**:**

Physical a ☐ Yes ☐ No notional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No

Domestic ce☐ Yes ☐ bandonm ☐ Yes ☐ No Neglect ☐ Yes ☐ No

Age(s) at tim buse: _____ Treatment received: _____

Wh was per tor? _____

Re hori _____ Find sitio _____

Did client witne y types use l ab : ☐ ☐

If yes, which ty of abuse? _____

Who was the victim? _____ Wh s the etrat _____

Has client been the perpetra of abuse ☐ N Wh as the m? _____

If yes, which type of abuse? _____

Addiction/Substance Use History (If you d mor ace u ck page)**:**

Substance	Yes	No	Substance	es	o	Substar	Yes	No
Alcohol	☐	☐	Pain Pills	☐	☐	Marij	☐	☐
Tranquilizers	☐	☐	Stimulants	☐	☐	Inhal	☐	☐
Sleeping Pills	☐	☐	Narcotics	☐	☐	Foo	☐	☐
Hallucinogens	☐	☐	Heroin/Meth	☐	☐	Se		☐
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: _____

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 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 getting together? _____
_____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with parent/child 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't trust about what problems? _____
Please describe any difficulties you are having socially: _____
_____

Family History (Please list those family members with <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: _____
_____

Prenatal health issues: _____

_____

Birth Trauma (C-section, birth injuries, complications): _____

_____

Developmental Milestones: Describe any problems with the following:

Attachment/bonding: _____

Motor skills: _____

Toileting: _____

Speech/langua_____

Social Skills_____

Temperame_____

Sexual His

Age at first s_____ experie_____

On a scale of _____, 10 b_____ ver_____tisfied, h_____ld you rate your sexual experiences: _____

On _____cale of _____0, 10_____g ve_____atisfied _____w _____sfied are _____th your sexual self-image: _____

On _____10, _____ ve_____atisfie_____ow_____tisfied a_____ith th_____equency of sex: _____

Plea_____be a_____ties y_____re_____ing: _____

_____

_____

Health and Nutrition:

How many cups of whole fresh fruits, vege_____les do _____eat d_____? _____

How much caffeine do you consume daily (8 oz cu_____f coff_____a, 12 oz sodas_____)_____

How much tobacco do you smoke/chew daily? _____

How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Month_____e

How much processed food do you eat: 1-3 Daily 1-3 Weekly 1-3 Mon_____ None

Exercise level and type: None 2-3 x's week 4-6 x's week Cardi_____ St_____th training

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 exce_____nt

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: _____

_____

_____

Spiritual History:

Do you believe in God? Yes/No Do you believe in Jesus Christ? Yes/No

Do you have a religious affiliation with which you are active? Yes/No

Do you feel you have a personal relationship with Jesus Christ? Yes/No

Do you believe that the Bible is God's word to mankind and contains truth for your life? Yes/No

How does your faith help you to cope with life's problems? _____

_____

_____

What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, Bible reading, Bible study, worship etc.)?_____

_____

Please describe any difficulties you are having concerning your faith _____

_____

_____

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 of your part to make these changes? _____
_____
_____

How will you know when you have accomplished your goals in counseling? _____
_____
_____

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

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 _____