

## Client History and Information

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Age/DOB: \_\_\_\_\_

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

Race/Ethnicity: \_\_\_\_\_

Religion: \_\_\_\_\_

Marital Status:  Married  Never married  Separated  Divorced  Widowed

Spouse name: \_\_\_\_\_

Living Situation: \_\_\_\_\_

**If the above patient is a minor complete the following:**

Name of Guardian: \_\_\_\_\_

Address of Guardian: \_\_\_\_\_

Phone Number of Guardian: \_\_\_\_\_ May we leave a message?  Yes  No

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

**Emergency Contact Information**

In case of an emergency, who should we contact?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

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

**Presenting Problem**

Who is providing the history information?  Client  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 or phrases that describe what you are experiencing.**

- Substance abuse/dependence/addiction
- Depression/sad/down feelings
- High/low energy level
- Crying spells
- Angry/Irritable
- Loss of interest in activities/difficulty enjoying things
- Mood swings
- Change in weight or appetite
- Change in sleeping pattern
- Self-harm/cutting/burning yourself
- Poor concentration/Difficulty focusing
- Feelings of hopelessness/Worthlessness
- Feelings of shame or guilt
- Feelings of inadequacy/low self-esteem
- Withdrawing from people/Isolation
- Anxious/nervous/tense feelings
- Panic attacks
- Racing or scrambled thoughts
- Flashbacks/Nightmares
- Hearing voices/seeing things not there
- Paranoid thoughts/thoughts that someone is watching you, out to get you or hurt you
- Thoughts of running away
- Perfectionism
- Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
- Binge eating/Purging
- Excessive exercise
- Job problems
- Other \_\_\_\_\_

**Add details for any checked items:**

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**History of Presenting Problem**

Have you received or participated in previous counseling and/or therapy?  Yes  No

Describe your previous treatment experience.  N/A

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Have you had hospital stays for psychological concerns?  Yes  No

Are you currently experiencing thoughts of harming yourself or someone else?  Yes  No

Have you in the past experienced thoughts of harming yourself or someone else?  Yes  No

**Medical History**

List any current or important past medications, their dose and your response to them.

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List any history of serious childhood illnesses.

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List any other health concerns, serious illnesses, head injuries, seizures, conditions, or major operations requiring hospitalization during your lifetime.

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List any allergies.

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How would you rate your current physical health?

Excellent Very Good Good Fair Poor Very Poor

What was the date of your last physical or routine health check-up? \_\_\_\_\_

Do you have a primary care physician? Yes No

If yes, who is your primary care physician, address and phone number?

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Will you give consent to coordinate care with your PCP? Yes No

How many caffeinated drinks do you consume each day/week?

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Do you use nicotine in any form? Yes No Include type and amount below.

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Do you have a healthy diet? Yes No Give more detail below.

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Do you exercise? Yes No Give details below.

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### Family History

Who were you raised by? Mother Father Step-mother Step-father Other \_\_\_\_\_

Rate your relationship with:

Mother: Good Fair Poor Close Distant Other \_\_\_\_\_

Father: Good Fair Poor Close Distant Other \_\_\_\_\_

Step-parent: Good Fair Poor Close Distant Other \_\_\_\_\_

Other: \_\_\_\_\_ Good Fair Poor Close Distant Other \_\_\_\_\_

List your siblings and describe your relationship (Good, fair, poor, close, distant, etc.) with them?

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have a history of neglect, and/or physical, verbal, emotional, or sexual abuse?

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Do you have a family history of substance abuse, mental illness, suicide, or violence?

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**Developmental History**

Did you walk, talk, and read on time?

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Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

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**Social and Recreational History**

Describe your relationship with peers and/or friends?

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Describe your hobbies/interests:

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**Sexual and Relationship History**

What is your sexual orientation? \_\_\_\_\_

What is the date you were married, separated, divorced or widowed? \_\_\_\_\_

If you are or were married please briefly describe nature of your marital relationship/separation/divorce:

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Please list any previous marriages/significant relationships from age 18 including current with name, date and the nature of the relationship.

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Do you have children? Yes No

If yes, list each child's name, age, gender and the nature of the relationship.

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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, what is the name and number of your caseworker? (They will not be contacted without your consent.)

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**Spirituality**

Do you have any spiritual beliefs that you wish to include in therapy?

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**Legal and Military History**

Do you currently have any pending criminal charges? Yes No

Are you on probation? Yes No

If yes, what is the name, county and phone number of your probation officer? (They will not be contacted without your consent.)

If you are on probation, will you give consent for your probation officer? Yes No

Have you ever been arrested/convicted of a crime? Yes No

**If yes, complete this chart:**

List any Arrests/Convictions	Date of Arrests/Convictions	Outcome

List any involvement in any legal cases. (Bankruptcy, divorce, lawsuits, etc.)

Have you ever been in the military?  Yes  No

If yes, what branch and rank? N/A

Any additional Information

**Educational History**

When attending school where you: Regular classes Home Study Cyber School Special classes  
Advanced classes Other

Did you have any problems in school? (Suspension, dropped out, learning disability, etc.)

What is the highest education level you achieved and when did you achieve it?

Any additional educational information? (College major, GED, etc.)

**Employment History**

What is your current employment status? Employed Full-Time Employed Part-time Unemployed  
Self-employed Student Other

Are you satisfied with your employment? If not, why?

In what fields have you worked?

**Substance Abuse History**

Are you currently or have you ever struggled with substance abuse?  Yes  No

If you answered yes, complete the following chart:  N/A

Substance Used	Age of First Use	Amount Used	Frequency of Use	Date of Last Use	How was it used?

Complete the following chart if you have ever received treatment for substance abuse.  N/A

Name of Treatment Program	Type of Treatment	Date of Treatment	Outcome

**Additional Information**

Summarize your goals for counseling/therapy:

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Do you have any cultural concerns? If so, what?

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Is there any additional information that you believe is important for your counselor to know in order to provide you with the best care possible?

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_