Client History and Information

Date: _____________ Patient Name: ________________________

Date of Birth: ________________________Gender: [ ] Male [ ] Female

Home Address: ____

Home Phone Number: _______________Work Phone Number: _______________

Mobile Phone Number: _________________________

If the above patient is a minor complete the following:

Name of Guardian: ________________________________

Address of Guardian: ____

Guardian's Home Phone: _______________Guardian's Work Phone: ________________

Referral Source: ___________________________________

Who referred you to our office, or how did your learn about this practice?

Emergency Contact Information:

In case of an emergency, who should we contact?

Name: __________________________________Relationship:_________________

Address: ____

Phone Number: ______________________

History Information

Please describe the current complaint or problem as specifically as you can, in your own words.

____

____

Check all words/phrases that describe what you are experiencing and explain if possible.

Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.

[ ] Depression/Sad/Down feelings

[ ] High/Low energy level

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Hearing voices/seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Feelings of being cheated

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:

Previous Treatment

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

Additional Information:

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

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

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

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?
[ ] Yes [ ] No If yes, explain: ____

Medical History

List any current or important past medications

Medication & Dose:

____

____

History of serious childhood illnesses:

____

____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

Have you experienced any head injuries? [ ] Yes [ ] No

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, complete the following:

Name

Address

Phone Number

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (Alcohol, tobacco, marijuana, caffeine, or other)[ ] Yes [ ] No

If you answered yes, please complete the following substance abuse history chart.

Substance

Ever Used Yes/No

Age of First Use

Frequency of Use

(Daily, Weekly, Monthly)

Amount Used

How did you use it? (Smoked, injected, etc.)

Alcohol

Marijuana

Cocaine or Crack

Heroin

Amphetamines

Club Drugs (Ecstasy, Inhalants, etc.)

Pain Medication (OxyContin, Vicodin, etc.

Benzodiazepines

Hallucinogens

Other

Additional Information:

Summarize your goals for counseling/therapy:____

____

____

What expectations do you have for counseling/therapy?

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

_______________________________ _______________________________

Signature of client or guardian Date