

COUNSELING HISTORY

Previously sought counseling: Y / N

Previously sought counseling for **current** problem: Y/N

Name of counselor When (month/year)? # of sessions Problem addressed Helpful? (Y/N)

Things **liked** about previous counseling: _____

Things **disliked** about previous counseling: _____

PSYCHIATRIC HISTORY/HOSPITALIZATION

Currently under psychiatric care? Y / N If yes, please explain below:

Name of Doctor Where How Long? Diagnosis

Received **previous psychiatric** treatment? Y / N If yes, please explain below:

Name of facility/hospital and/or doctor When (month/year) Length of stay (if hospitalized) Diagnosis

HEALTH/MEDICAL INFORMATION

Current **physical health?** Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Presently taking any medication? Y / N If **yes**, please **list medications**, the **purpose** for each and **doctor prescribing** medication: _____

Having problems with sleep habits? Y / N If Yes, circle where applicable:

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other _____

Having difficulty with appetite or eating habits? Y / N If Yes, circle where applicable:

Eating less Eating more Binging Restricting intake

Suicidal thoughts recently? Never Rarely Sometimes Frequently

Suicidal thoughts in the past? Never Rarely Sometimes Frequently

SOCIAL/SUPPORT INFORMATION

Who does client rely on for emotional support? _____

Quality of social relationships?

Excellent Good About Average Unsatisfactory Very Poor

Besides family members, approximately how many people can the client really count on right now for friendship and/or emotional support? _____

Current or **past** legal problems? Y / N If yes, please explain: _____

LIFESTYLE INFORMATION

How many times per week does client exercise? _____ For about how long each time? _____

Type of exercise: _____

Does client engage in recreational drug use? Y / N If yes, how often: Daily - Weekly - Monthly - Rarely

Does client consider this drug use a problem? Y / N _____

Does the client smoke? Y / N If yes, how many cigarettes/packs a day: _____

of hours of sleep client receives per night (average): _____

Does client have problems with weight? Y / N If yes, explain: _____

Alcoholic beverages consumed per week: _____

Do you consider your alcohol consumption a problem? Y / N _____

What does client do with their leisure/free time? _____

Other Agencies involved with you and/or your Family? Y / N If yes, please list/explain: _____

LIVING ARRANGEMENTS

Please list **names, ages, occupations, and relationships** of those people living with you:

Is there anyone significant that was living in the home that is (or was) an important part of your life?
(Names, Ages, Occupations, Relationship)

ABUSE HISTORY

Have you personally experienced any form of abuse? None - Emotional - Physical – Sexual
If so, briefly explain **who, what, when, disclosure information, etc.:**

FAMILY TRAUMA

Please check any **past, present, or impending** special **problems in your family**: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Financial crisis/unemployment | <input type="checkbox"/> Deaths | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Physical/sexual abuse | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Frequent relocations |
| <input type="checkbox"/> Attempted/completed suicides | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Debilitating injuries/disabilities | <input type="checkbox"/> Serious illness | <input type="checkbox"/> Other _____ |

Please specify family member(s), which problem, and approximate year of occurrence (e.g. mother-serious illness-1998, etc.) _____

FAMILY HISTORY

Does anyone in your family have a history of psychiatric illness? Y / N

If Y, explain: _____

Has anyone in your family been in counseling before? Y / N

If Y, explain: _____

MARRIAGE/PERSONAL RELATIONSHIPS

Client Marriage/Divorce History (for children/teens: parents' marriage/divorce history)

Current Marriage/Relationship Difficulties (for children/teens: parents' communication, decision making, discipline styles, difficulties, etc.)
