

HERSTORY/HISTORY

Today's Date: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

May I leave a message at either of these numbers? \_\_\_\_\_

Email Address \_\_\_\_\_ Birth Date \_\_\_\_\_

Are you planning to submit my bills to your insurance company for reimbursement? \_\_\_\_\_

Present situation

Please state why you decided to come for counseling at this time.

\_\_\_\_\_

What is the nature of your situation?

\_\_\_\_\_

What have you tried in the past to address this issue?

\_\_\_\_\_

How long has this been a problem for you? \_\_\_\_\_

Please state what you would like to work on in therapy.

\_\_\_\_\_

\_\_\_\_\_

Work history

Occupation \_\_\_\_\_ How long \_\_\_\_\_

If presently unemployed, describe the situation \_\_\_\_\_

\_\_\_\_\_

Hobbies/Passions \_\_\_\_\_

What three words would you use to describe:

Yourself: \_\_\_\_\_

Your Father: \_\_\_\_\_

Your Mother \_\_\_\_\_

God: \_\_\_\_\_

Spiritual History

Religious upbringing \_\_\_\_\_ Present Affiliation \_\_\_\_\_

Is this an important part of your life? \_\_\_\_\_ Why/Why not? \_\_\_\_\_

Physical/Mental Health History

General Health \_\_\_\_\_

Any recurrent or chronic conditions? \_\_\_\_\_

Are you taking any medication? \_\_\_\_\_ If yes, please list:

Type of medication Reason for medication How long have you been taking it

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_ Do you wake up in the night? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes how often/how much? \_\_\_\_\_

Do you use drugs? \_\_\_\_\_ If yes, what and how often? \_\_\_\_\_

Have you ever been hospitalized for a mental illness? \_\_\_\_\_ Describe \_\_\_\_\_

Have you ever received treatment for alcohol and/or drugs? \_\_\_\_\_ Describe \_\_\_\_\_

Any previous counseling/therapy? \_\_\_\_\_ If yes, when was it, for how long, and what was the result?

\_\_\_\_\_  
\_\_\_\_\_

Family Information

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as patient:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation with above : \_\_\_\_\_

Parents:

Father alive \_\_\_\_\_ Where residing? \_\_\_\_\_ Relationship \_\_\_\_\_

Mother alive \_\_\_\_\_ Where residing? \_\_\_\_\_ Relationship \_\_\_\_\_

Parents divorced? \_\_\_\_\_ If yes, your age at that time \_\_\_\_\_

If deceased, your age at the time \_\_\_\_\_ Cause of death \_\_\_\_\_

Any step-parents? \_\_\_\_\_ If yes, describe your relationship with them \_\_\_\_\_

\_\_\_\_\_

Family Alcoholism or Domestic Violence? \_\_\_\_\_ Sexual Addiction or Abuse? \_\_\_\_\_

Siblings:

First name	Age	Relationship (also please indicate if they are deceased)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you married? \_\_\_\_\_ # of marriages \_\_\_\_\_ Spouse's name \_\_\_\_\_

Living with a partner? \_\_\_\_\_ How long? \_\_\_\_\_ Partner's name \_\_\_\_\_

Are you in an intimate relationship right now? \_\_\_\_\_ Please describe any past or current significant issues in intimate relationships.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any past or current significant issues in other immediate family relationships: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

Emotional status

Please respond to each of the following symptoms by indicating in the boxes provided how much of a problem they have been in the last 2 weeks using the following scale:

1 - Serious problem

2- Moderate problem

3 - Minor problem

4 - Not a problem

- |                               |                                     |  |
|-------------------------------|-------------------------------------|--|
| _____ depressed mood          | _____ substance abuse               | _____ compulsive sexual behavior                       |
| _____ compulsive behavior     | _____ overly detailed thoughts      | _____ compulsive spending                              |
| _____ anger                   | _____ jumping from topic to topic   | _____ gambling   |
| _____ increased appetite      | _____ delusions                     | _____ excessive clutter in home                        |
| _____ decreased appetite      | _____ hallucinations                | _____ thoughts of death/suicide                        |
| _____ problems with sleep     | _____ hearing voices                | _____ loss of interest (in things<br>you once enjoyed) |
| _____ poor judgement          | _____ aggressive behavior           | _____ a medical condition                              |
| _____ excessive worry         | _____ conduct problems              | _____ emotional trauma victim                          |
| _____ elimination disturbance | _____ oppositional behavior         | _____ physical trauma victim                           |
| _____ fatigue/low energy      | _____ sexual dysfunction            | _____ sexual trauma victim                             |
| _____ slow movements          | _____ grief                         | _____ emotional trauma<br>perpetrator                  |
| _____ poor concentration      | _____ hopelessness                  | _____ physical trauma perpetrator                      |
| _____ mood swings             | _____ social isolation              | _____ sexual trauma perpetrator                        |
| _____ agitation               | _____ worthlessness                 |  |
| _____ emotionality            | _____ guilt                         |  |
| _____ irritability            | _____ elevated mood                 |  |
| _____ generalized anxiety     | _____ hyperactivity                 |  |
| _____ panic attacks           | _____ losing track of time or place |  |
| _____ phobias                 | _____ physical complaints           |  |
| _____ bingeing/purging        | _____ self mutilation               |  |
| _____ laxative/diuretic use   | _____ significant weight loss/gain  |  |
| _____ anorexia                | _____ nightmares                    |  |
| _____ paranoid ideas          | _____ flashbacks                    |  |

Have you had any thoughts of suicide? \_\_\_\_\_ Do you have any thoughts now? \_\_\_\_\_

*Thank you for completing this form.*