

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Abortions |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Trauma | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Religious Upbringing | <input type="checkbox"/> Major Losses | <input type="checkbox"/> Multiple Marriages | |

Please describe the kind of family you grew up in: _____

What are your religious/spiritual beliefs?: _____

How important are they? _____

Employment / Education

Employer/School Name: _____ Occupation/Grade: _____

Employer /School Number: _____ May I contact at this number? Yes No

Highest Grade Completed: _____

Counseling History

Please state a brief description of primary concern and main reason for seeking counseling:

Have you previously been in counseling? Yes No

Name of Therapist/Program	Inpatient or Outpatient	Issues Addressed	Dates

Any past suicidal thoughts?: Yes No If Yes, when?: _____

Outcome? (Hospitalization? etc): _____

Any current suicidal thoughts? Yes No Do you have a plan?: _____

Method?: _____ Additional suicidal Information: _____

Any homicidal ideations?: Yes No

Are you on any psychotropic medications? Yes No List medications: _____

Who prescribes medication? _____

Any family history of mental history? Yes No Describe: _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Alcohol Use / Dependence | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Marital problems | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gambling | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Grief / Loss | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Gender identity | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Phobias/fears | <input type="checkbox"/> Unwanted memories |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Verbal abuse |
| <input type="checkbox"/> Compulsive Behaviors | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Disorientation / Indecisiveness | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Recurring thoughts | <input type="checkbox"/> Worthlessness |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Irritability | <input type="checkbox"/> Relational issues | <input type="checkbox"/> Work Issues |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Isolation / Loneliness | <input type="checkbox"/> Seeing things others don't | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug Use / Dependence | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Other (specify): _____ |

Medical History

Name of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

Substance Abuse History

Have you or others had concerns about your use of alcohol or other drugs? Yes No

Have you ever tried to control your drinking or drug use? Yes No

Do you classify yourself as an alcoholic or addict? Yes No

If yes, what is your drug of choice? _____

Have you ever had treatment for alcohol/drugs? Yes No

If yes, where and when? _____

Chemical Type	Age of Onset	Age of Regular Use	Frequency, amount of use, type, method	Last Use
<u>Alcohol</u> Beer, Wine, Liquor				
<u>Cocaine Crack</u>				
<u>Cannabinoids</u> Marijuana, Hash				
<u>Amphetamines</u> Crystal Meth, Crank, Speed, Ice, Diet Pills, Benzedrine, Dexedrine, Ritaline, Ecstasy, Methedrine				
<u>Hallucinogens</u> PCP, LSD, STP, Mescaline, Mushrooms, Peyote, Acid, Ketamone				
<u>Sedatives</u> Downers, Quaaludes, GHB <u>Sleeping Pills</u> Ambien, Seconal <u>Tranquilizers</u> Mellaril, Thorazine, Haldol				
<u>Benzodiazepines</u> Valium, Librium, Xanax, Ativan, Tranxene, Klonopin, Serax, Centrax				
<u>Opiates</u> Heroin, Demerol, Codeine, Methadone, Morphine, Dilaudid, Percodan, Darvon, Lortab, Opium, Percocet, Oxycontin, Soma, Vicodin, Hydrocodone				
<u>Inhalants</u> Gasoline, Glue, Freon				

Client Signature _____

Date _____