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Welcome!

The information you provide will be kept strictly confidential.

Today's Date_________________

General Information

Name_________________________ Date of Birth ________________ Age ________ Sex: M F

Address____
(Street) (City) (State) (Zip)

Phone: Home (_____) ______________________________Work (_____) ____________________

Cell (_____) ______________________________ OK to leave message? Y / N Text? Y / N

Email address____

Occupation____

Employer ____ Length Employed____________

Marital Status: Single______ Married______ Separated______ Divorced_____ Widowed______

If married, years wed? _________________ If previously married, years wed? _________________

Name of Spouse_____________________________ Spouse's Date of Birth_________________

Spouse's Occupation & Employer____

Emergency Contact

Emergency Contact: _______________________________ Relationship_____________________

Address: ____

Phone:_____________________________________

Social History

Please list the people who currently live with you:

Name	Relationship	Age
______________________	_______________________	__________
______________________	_______________________	__________
______________________	_______________________	__________
______________________	_______________________	__________

Do you have any children who do not live with you?

Name	Age	City
______________________	__________________	_______________________
______________________	__________________	_______________________

Please describe your social support (do you have friends/family you can count on?)

____

What are you hobbies/special interests?

____

Educational/Occupational History

What is your level of education: ____

What jobs have you held in the past 10 years: ____

Religion/Spirituality

Do you have a religious or spiritual orientation? ____

If so, what is your religious/spiritual practice: ____

Is religion/spirituality important in your treatment? Y / N

Culture

Ethnicity: ____

Place of birth: ____

Languages spoken: ____

Is there anything you would like therapist to know about your culture? _______________________

____

Legal History

Please list any present or past history of arrest, court involvement, or other legal problems:

____

Developmental History

Did you meet all of your developmental milestones on time (i.e. sitting, crawling, standing, walking, eating, speaking)? Y/N

If no, please explain:____

____

Medical History

Name of personal physician___________________________________

Physician phone #: ____

Date of last medical exam_____________________________________

List important illnesses, injuries, or disabilities, past and present:

____

____

Are you presently taking medication? Y / N

If so, list name(s) and dosage____

Prescribing Physician: ____

Substance Use

Do you drink alcohol? Y / N Amount/frequency_____________________________________

When did you begin drinking? ____

Do you smoke cigarettes? Y / N Amount/frequency___________________________________

When did you begin smoking? ____

Do you smoke marijuana or use any other drugs? Y / N If yes, what substances?

____

Amount/frequency_____________________ When did you begin using? __________________

Have you ever received treatment for any substance abuse? Y / N If yes, when and where:

____

Do any family members have a history of substance abuse? Please explain:

____

Mental Health History

Have you ever received counseling before? Y / N If yes, when? ______________________

Name of Previous Counselor: ____

Have you been given a previous mental health diagnosis? ________________________________

Have you ever been hospitalized for mental/emotional difficulties? Y / N

If yes, give dates and reason:

____

Have you ever been suicidal or made a suicidal attempt? Y / N If yes, please explain:

____

____

Has anyone in your family ever had an emotional or mental health problem? Y / N

If so, please explain:____

____

History of Violence/Abuse/Trauma

Do you have a history of violence? Y / N Briefly explain: ___________________________________
____

Have you ever been physically, emotionally, or sexually abused? Y / N Briefly explain: _____________
____

Have you experienced anything else in your life that you consider traumatic? Y/N
Briefly explain: ____
____

Current Problems

Briefly describe the problem(s) for which you are seeking treatment:
____
____

On the scale below, please circle the most accurate description of the severity of your problem(s):

mild   moderate   difficult   severe

When did the problem(s) start? ____

Please list three hopes/ expectations for counseling at this time:

1) ____
2) ____
3) ____

Any other information that would be helpful for the therapist to know at this time?
____
____

I, ____, verify that the above information is true and correct.

_____________________________________ _____________________
(Client Signature) (Date)

_____________________________________ _____________________
(Parent/Guardian Signature) (Date