**Client Information & History Form**

The purpose of this form is to provide me with information that will be relevant to your treatment. Please allow yourself at least 15-20 minutes to complete it. I keep this form as part of your records and may look back through it during our time together. I appreciate the time you are taking to do this.

General Information

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

Date of Birth:(MM/DD/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pro-noun:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Marital Status: Single Engaged Married Separated Divorced

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Preferred Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work

Secondary Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Cell Work

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Communication Preference: Email Text

Are you currently employed? Yes No

Employer/Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Furthest level of education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently in school? Y N

School Currently Attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is minor, does guardian have sole custody?

**Medical Information**

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you categorize your overall physical health? (please circle)

Poor Fair Good Excellent

What do you do to contribute to your physical health? (i.e., exercise, dieting)

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Please circle areas of concern regarding your physical health:

Over-Sleeping Sudden Weight Gain Increased Sexual Desire Increased Energy Under-Sleeping Sudden Weight Loss Decreased Sexual Desire Decreased Energy

Please list any current major illnesses/injuries:

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Are you currently taking any medication? Please list the name, dosage/frequency, purpose, prescribing physician & effectiveness/results.

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Have you even been hospitalized for mental health reason? ( If yes, please provide dates and where)

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Do you use tobacco? (If yes, please list amount/frequency & describe your history with use)

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Do you use alcohol? (If yes, please list amount/frequency & describe your history with use)

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Do you use recreational drugs? (If yes, please list amount/frequency & describe your history with use)

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Have you ever had any thoughts of hurting yourself or someone else?

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Have you ever attempted suicide?

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Are you currently at risk for hurting yourself? (If yes, please explain and address how you would like to see that changed)

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**Presenting Symptoms and Trauma**

Symptoms (please check all that apply)

Aggression/fights Food Concerns Memory Loss

Seasonal mood changes Alcohol/Drug use Nightmares

Self-harm behaviors Anxiety/Worry Guilt/Shame

Obsessive thoughts/behaviors Sexual problems Hallucinations

Hearing voice Panic attacks Sleep problems

Boredom Parenting problem Hypervigilance

Social discomfort Hopelessness Cry easily

Impulsivity Phobias Irritability

Easily angered Feel stressed Flashbacks

Can’t remember things Sad/ Depressed Often fearful

Can’t concentrate Low self-worth Loneliness

Racing thoughts Work/school problem Mood swings

Loss of interest Eating too much Can’t eat

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Trauma(Please check any you have experienced)

Emotional/Verbally abuse Living in a foster home Neglect

Sexual abuse Domestic violence Homelessness

Teen pregnancy Physical abuse Loss/ grief

Witness of physical abuse Medical Community bully

Culture violence/bully School violence War

Parent substance abuse Witness of drug use Natural disaster

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family & Psychosocial Information**

How would you describe your relationship with your mother (current & past)?

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How would you describe your relationship with your father (current & past)?

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Are your parents married, divorced, separated? If they are divorced/separate, how old were you when they divorced/separated?

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Are there any other primary caretakers you have had a significant relationship with (current & past)?

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Do you have any siblings? (If yes, please list their name, gender & age)

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Describe your relationship with your siblings (current & past)

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Do you have children? (If yes, please list their name, gender & age)

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Please describe your relationship with your children (current & past if applicable).

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Who is currently living in your home?

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To your knowledge, is there any history of addiction in your family?

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To your knowledge, is there any history of mental illness in your family?

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To your knowledge, is there any history of physical, sexual, emotional abuse or neglect in your family?

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To your knowledge, is there any history of violence or other trauma in your family?

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Is there anything else about your family history that would be important for me to know? How supportive is your family to your overall mental health? (1= not at all supportive, 5=highly supportive)

1 2 3 4 5

Who is a part of your social support system?

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Are you current employed/ school/ or status of economic status? Is this a strength or a stressor? Please describe.

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Please describe any cultural or religious beliefs that are important to you.

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Are there any sexual orientation or gender issues/concerns?

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Are you involved in any organizations/groups/clubs? Have there been any major life stressors in the past year (such as divorce, serious illness, death of a close one, job change, move, new member of the family)?

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Is there anything else that you would like for me to know?

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