



Are you currently in a romantic relationship?  Yes  No

If yes, how long have you been in this relationship? \_\_\_\_\_

Assessment of current relationship (if applicable): \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_ Poor

**Marital Status** (more than one answer may apply)

Single \_\_\_\_\_ Divorce in process \_\_\_\_\_ Unmarried, living together  
 Length of time: \_\_\_\_\_ Length of time: \_\_\_\_\_  
 Legally married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced  
 Length of time: \_\_\_\_\_ Length of time: \_\_\_\_\_ Length of time: \_\_\_\_\_  
 Widowed \_\_\_\_\_ Annulment  
 Length of time: \_\_\_\_\_ Length of time: \_\_\_\_\_ Total number of marriages: \_\_\_\_\_  
 Assessment of current relationship (if applicable): \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_ Poor

**Parental Information**

Parents legally married \_\_\_\_\_ Mother remarried: Number of times: \_\_\_\_\_  
 Parents have ever been separated \_\_\_\_\_ Father remarried: Number of times: \_\_\_\_\_  
 Parents ever divorced  
 Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): \_\_\_\_\_

**Development**

Are there special, unusual, or traumatic circumstances that affected your development? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Has there been history of child abuse? \_\_\_\_\_ Yes \_\_\_ No

If yes, which type(s)? \_\_\_\_\_ Sexual \_\_\_\_\_ Physical \_\_\_\_\_ Verbal

If yes, the abuse was as a: \_\_\_\_\_ Victim \_\_\_\_\_ Perpetrator

Other childhood issues: \_\_\_\_\_ Neglect \_\_\_\_\_ Inadequate nutrition \_\_\_\_\_ Other (please specify): \_\_\_\_\_

Comments re: childhood development: \_\_\_\_\_

**Social Relationships**

Check how you generally get along with other people: (check all that apply)

Affectionate \_\_\_\_\_ Aggressive \_\_\_\_\_ Avoidant \_\_\_\_\_ Fight/argue often \_\_\_\_\_ Follower  
 Friendly \_\_\_\_\_ Leader \_\_\_\_\_ Outgoing \_\_\_\_\_ Shy/withdrawn \_\_\_\_\_ Submissive  
 Other (specify): \_\_\_\_\_

Sexual orientation: \_\_\_\_\_ Comments: \_\_\_\_\_

Sexual dysfunctions? \_\_\_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Any current or history of being a sexual perpetrator? \_\_\_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

**Cultural/Ethnic**

To which cultural or ethnic group, if any, do you belong? \_\_\_\_\_

Are you experiencing any problems due to cultural or ethnic issues? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, describe: \_\_\_\_\_

Other cultural/ethnic information: \_\_\_\_\_

**Spiritual/Religious**

How important to you are spiritual matters?  Not  Little  Moderate  Much

Are you affiliated with a spiritual or religious group?  Yes  No

If yes, describe: \_\_\_\_\_

Were you raised within a spiritual or religious group?  Yes  No

If yes, describe: \_\_\_\_\_

Would you like your spiritual/religious beliefs incorporated into the counseling?  Yes  No

If yes, describe: \_\_\_\_\_

**Legal**

**Current Status**

Are you involved in any active cases (traffic, civil, criminal)?  Yes  No

If yes, please describe and indicate the court and hearing/trial dates and charges: \_\_\_\_\_

Are you presently on probation or parole?  Yes  No

If yes, please describe: \_\_\_\_\_

**Past History**

Traffic violations:  Yes  No

DWI, DUI, etc.:  Yes  No

Criminal involvement:  Yes  No

Civil involvement:  Yes  No

If you responded yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Education**

Fill in all that apply: Years of education: \_\_\_\_\_ Currently enrolled in school?  Yes  No

High school grad/GED

Vocational: Number of years: \_\_\_\_\_ Graduated:  Yes  No Major: \_\_\_\_\_

College: Number of years: \_\_\_\_\_ Graduated:  Yes  No Major: \_\_\_\_\_

Graduate: Number of years: \_\_\_\_\_ Graduated:  Yes  No Major: \_\_\_\_\_

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

Special circumstances (e.g., learning disabilities, gifted): \_\_\_\_\_

**Employment**

Begin with most recent job, list job history: \_\_\_\_\_

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently:  FT  PT  Temp  Laid-off  Disabled  Retired

Social Security  Student  Other (describe): \_\_\_\_\_

**Military**

Military experience? \_\_\_ Yes \_\_\_ No

Combat experience? \_\_\_ Yes \_\_\_ No

Where: \_\_\_\_\_

Branch: \_\_\_\_\_ Discharge date: \_\_\_\_\_

Date drafted: \_\_\_\_\_ Type of discharge: \_\_\_\_\_

Date enlisted: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

(Check if exercise)	Activity	How often now?	How often in the past?
<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____

**Medical/Physical Health**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS            | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Nose bleeds                   |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Drug abuse             | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Abortion        | <input type="checkbox"/> Ear infections         | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Eating problems        | <input type="checkbox"/> Sleeping disorders            |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Sore throat                   |
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Scarlet Fever                 |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Frequent urination     | <input type="checkbox"/> Sinusitis                     |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Smallpox                      |
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Hearing problems       | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Bed wetting     | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Sexual problems               |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Tonsillitis                   |
| <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Kidney problems        | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Chronic pain    | <input type="checkbox"/> Measles                | <input type="checkbox"/> Toothache                     |
| <input type="checkbox"/> Colds/Coughs    | <input type="checkbox"/> Mononucleosis          | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Vision problems               |
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Menstrual pain         | <input type="checkbox"/> Vomiting                      |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages           | <input type="checkbox"/> Whooping cough                |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____       |
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Nausea                 | _____  |

List any current health concerns: \_\_\_\_\_

List any recent health or physical changes: \_\_\_\_\_

Are you having any problems with your sleep habits?  Yes  No

If yes, check where applicable.

Sleeping too little?  Sleeping too much?  Poor quality sleep?

**Nutrition**

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High

Comments: \_\_\_\_\_

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: \_\_\_\_\_

Please check if there have been any recent changes in the following:

\_\_\_ Sleep patterns      \_\_\_ Eating patterns      \_\_\_ Behavior      \_\_\_ Energy level  
 \_\_\_ Physical activity level      \_\_\_ General disposition      \_\_\_ Weight      \_\_\_ Nervousness/tension

Describe changes in areas in which you checked above: \_\_\_\_\_

### Chemical Use History

	Method of Use and amount	Frequency of use	Age of first use	Age of last use	Used in last		Used in last	
					48 hours		30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance of preference

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

#### Substance Abuse Questions

Describe when and where you typically use substances: \_\_\_\_\_

Describe any changes in your use patterns: \_\_\_\_\_

Describe how your use has affected your family or friends (include their perceptions of your use): \_\_\_\_\_

Reason(s) for use:

Addicted       Build confidence       Escape       Self-medication  
 Socialization       Taste       Other (specify): \_\_\_\_\_

How do you believe your substance use affects your life? \_\_\_\_\_

Who or what has helped you in stopping or limiting your use? \_\_\_\_\_

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes  No      If Yes, describe: \_\_\_\_\_

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?  Yes  No

If yes, describe: \_\_\_\_\_

Have you had adverse reactions or overdose to drugs or alcohol? (describe): \_\_\_\_\_

Does your body temperature change when you drink?  Yes  No

If yes, describe: \_\_\_\_\_

Have drugs or alcohol created a problem for your job?  Yes  No

If yes, describe: \_\_\_\_\_

### Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

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"/> Elevated mood       | <input type="checkbox"/> Phobias/fears          |
| <input type="checkbox"/> Alcohol dependence  | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Recurring thoughts     |
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Sexual addiction       |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Sexual difficulties    |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Sick often             |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems      |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Speech problems        |
| <input type="checkbox"/> Cyber addiction     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Suicidal thoughts      |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Thoughts disorganized  |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Trembling              |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Withdrawing            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Worrying               |
| <input type="checkbox"/> Drug dependence     | <input type="checkbox"/> Mood shifts         | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Panic attacks       | _____   |

### FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

	Family Member(s)	Family Member(s)
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Bipolar <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Suicide Attempts <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Anxiety Dsrdrs <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Lrnng Disabltcs	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Trauma History <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	

Briefly discuss how the above symptoms impair your ability to function effectively: \_\_\_\_\_

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

What attempts have you made (successful or unsuccessful) to resolve concerns / problems? \_\_\_\_\_

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

Any additional information that would assist us in understanding your concerns or problems: \_\_\_\_\_

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

What do you consider to be your strengths? \_\_\_\_\_

\_\_\_\_\_

What do you like most about yourself? \_\_\_\_\_

\_\_\_\_\_

What are effective coping strategies that you've learned? \_\_\_\_\_

\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

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

Do you feel suicidal at this time? \_\_\_\_ Yes \_\_\_\_ No Frequently?  Sometimes?  Rarely?  Never?

If yes, explain: \_\_\_\_\_

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

I recognize that the above information will be used in and form part of the basis for both my treatment and diagnosis.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Today's date

**For Staff Use**

Therapist's signature/credentials: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist's comments: \_\_\_\_\_

\_\_\_\_\_  
Physical exam: \_\_\_\_ Advised? \_\_\_\_ Not required