Family Counseling Center

Client's Personal and Medical History

To better assist us in providing you quality care, please answer the following questions as thoroughly and accurately as possible.

Client Name: _______________________________ Date of Birth: __________Gender:__________

Age: ________ Marital Status: ___________ Partner's Name: __________________ Age: ______

Live with Partner? ___________

Address: ____ Phone: _________________

If minor is being seen, parent's name and address: _____________________________________

____

If parents are divorced, name and address of other parent: _______________________________

____

Others living in client's home:

Name Relationship Age

____

____

____

____

____

Main reason for seeking counseling:

____

____

Have you been to counseling before? _________

If so, how long ago and with whom?

____

Was it helpful? __________________ was a diagnosis given? _____________

If so, what was it? ____

Please check any symptoms or problems you have experienced:

___trouble going to sleep or staying asleep
___low energy most days
___feelings sad or empty often
___crying almost daily
___loss of interest in pleasant activities
___feelings of worthlessness or guilt
___unable to concentrate often
___weight gain or weight loss
___thoughts of death or suicide
___feelings of hopelessness
___no interest in doing pleasurable things
___no appetite
___feeling anxious often
___feeling panicky
___worry about many things, most of the time
___it's hard not to worry
___I seem to be irritable often
___frequent muscle tension
___nervous
___restlessness
___anxious when with crowds
___fear of having a panic attack
___recurrent thoughts/impulses that cause anxiety
and prompt me to do things over and over
___feel like I could explode
___I experienced a traumatic event
___I can't trust anyone
___peculiar habits

___I have recurrent thoughts about a trauma
___I feel distressed when I am reminded of a trauma
___I have nightmares often
___I am always vigilant (on watch)
___I startle easily
___frequent conflict with spouse/partner
___frequent conflict with family members
___victim of domestic violence
___victim of physical abuse
___victim of emotional abuse
___victim of sexual abuse
___communication problems
___sexual difficulties
___financial problems
___difficulty making decisions
___conflict in workplace
___problem with alcohol/other drugs
(in the opinion of people near you)
___unusual thoughts
___hear voices that others don't
___see things that others don't
___other people are watching me
___dizziness
___headaches
___stomachaches
___other physical or medical problems:
____
____

Is this a crisis situation that demands immediate attention? ____________

Is there a history of mental illness in your family? _____________

If so, please list instances:

____

____

How often do you consume alcohol? _________ X per day ________X per week_______X per month________

Do you use any controlled substances? ________ If so, what? ____

Do you have a history of suicide attempts or gestures? ________

If yes, please list dates of occurrence: ____

Have you been incarcerated? __________ if yes, please state reason: __________________________________

Do you have a history of sexual offenses? ____

Have you ever been physically abused? _________

If yes, please list dates of occurrences:

____

____

Please list any medications that you are currently taking:

____

Name of Primary Care Physician: ____

Name of Psychiatrist (If applicable): ____

Any additional information you feel is important:

____

____

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