Rev. 7-2019

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? _____

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking any of the choices listed below.

- ☐ My therapist may call me on my home phone which is _____
- ☐ My therapist may call me on my cell phone which is _____
- ☐ My therapist may send a text message to my cell phone _____
- ☐ My therapist may call me at work phone which is _____
- ☐ My therapist may communicate with me by e-mail at _____
- ☐ My therapist may send mail to me at my home address _____

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

_____
_____
_____
_____
_____

What is (are) your main reason(s) for this visit?:

_____
_____

Are you receiving counseling services at present? _____ Yes _____ No

Have you received counseling in the past? _____ Yes _____ No

If so, how long ago and with whom?

_____

Was it helpful? _____ was a diagnosis given? _____

If so, what was it? _____

Have you ever been hospitalized for emotional problems? _____ Yes _____ No

If yes, why, when, where, and for how long?_____

Is this a crisis 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? _____

Have you ever attempted suicide? _____ Yes _____ No

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? _____

Have you ever experienced unwanted touch in your family or personal relationships? _____

Have you ever experienced other unwanted touch? _____
If yes, by whom?

_____

Please list any medications that you are currently taking:

_____

Are you considering or in the process of applying for Disability? _____

Are you involved in a custody suit regarding your children _____ Yes _____ No

Is the status of your Mental Health a part of any current/pending legal situation? _____ Yes _____ No

Name of Primary Care Physician: _____

Name of Psychiatrist (If applicable): _____

Any additional information you feel is important:

_____

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

___I seem to be irritable often

___frequent muscle tension

___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

___unusual thoughts (in the opinion of people near you)

___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:

_____

_____