Client History

Date:________________ Name:_______________________________________
First Middle Last

Please fill out this form as completely as you can to save time in our first session. The information is confidential and no one has access to it without your written permission.

Address: ____
Date of birth: _______ Age :_______

List phone numbers or email address I have permission to use to reach you:
____
Home Phone Business Phone Cell Phone

____
E-mail address

How were you referred? ____

YOUR EDUCATION / VOCATION

Highest degree of education: Grade G.E.D. College Degree Advanced Degree
Area of study: ____

Are you currently employed: No Yes Title:___________________________________

How long in this job: _______Months / Years Are you happy with the job? No Yes

List your main school or work difficulties:
____
____
____

YOUR RELATIONSHIPS

Your Gender Identity: __ Female __ Male__ Other__________________

Sexual Orientation (please choose all that apply):

___Heterosexual ___ Bi-sexual ___ Gay ___ Lesbian ___ Transgender Other _________

How would you describe your relationship status? (Married, domestic partnership, single, etc.)
____

Number of years with present partner: ____________________

Partner's highest education: Grade ____ G.E.D. College Degree Advanced Degree

Please list other significant long-term relationships:
____
____

List your main love and sex difficulties:____
____
____
____

Please list names and ages of children (living and deceased):
____
____

List any relational difficulties with children: ____
____

YOUR FAMILY OF ORIGIN

Your place of birth:____
City State Country

Ethnic background (Irish, English etc.) ____

The following are questions about your parents or parent substitutes:

Mother's age: ______ If deceased, how old were you when she died? ______
Father's age: ______ If deceased, how old were you when he died? ______
If your mother and father separated, how old were you at the time? ______
If your mother and father divorced, how old were you at the time? ______
Mother's level of education: __________current or former occupation: ____________________
Father's level of education: __________current or former occupation: ___________________________

Mother's religion: _____________________ Father's religion: __________________________

Briefly describe the type of person your mother (or stepmother or mother substitute) was when you were a child and how you got along with her:____
____
____
Briefly describe the type of person your father (or stepfather or father substitute) was when you were a child and how you got along with him: ____
____
____

Number of Siblings: ____Full Sisters ____ Full Brothers ____ ½ Sisters ____ ½ Brothers

____ Step Sisters ____ Step Brothers

I was child number ____in a family of ____ children Were you adopted? (circle) Yes No

Number of siblings deceased:______ Age(s) at time of death:___________________________

Describe relationship w/ Siblings:____
____

Are there mental health, emotional problems, drug or alcohol problems in your family? No Yes

Who:____ Type of Problem:_______________________

Has anyone in your family ever committed suicide or homicide?
No Yes Who:____

What difficulties did you have in your youth? ____
____

Were you ever physically / sexually abused? No Yes Don't Know

By whom:_______________________________________ Age on onset:_____________________

YOUR SOCIAL RELATIONSHIPS

How many close friends do you have? ______ How many acquaintances? ____________

Would you describe yourself as an extrovert or an introvert?___________________________________

List your main social difficulties: ____
____
____

YOUR MEDICAL HISTORY

List your chief physical ailments, diseases, complaints, or handicaps:_____________________________
____
____
____

Date of last physical exam: (month):_____________________ (year):_____________________

Primary Care Physician____________________________________City__________________________

Are you being followed by a Specialty Physician? _____ Dr.'s name:_____________________________

Reason:____

Please list any medications you are currently taking and their purpose:
____
____

How is your:

Sleep?	Good	Fair	Poor	Explain:______________________________________
Appetite?	Good	Fair	Poor	Explain:______________________________________
Sexual satisfaction?	Good	Fair	Poor	Explain:______________________________________

Do you have:
Any contagious diseases? No Yes What/when: ____
A disability or handicap? No Yes Describe: ____
Any allergies? No Yes If yes, please list:____________________________________

Have you had any:
Accidents/injuries? No Yes What/when:___________________________________
Surgeries No Yes What/when:___________________________________
Major Illness(es) No Yes What/when:___________________________________
Hospitalization(s) No Yes What/when:___________________________________
Bad reaction(s)to a drug, food, alcohol, over-the-counter product or environmental stimuli?
No Yes What/when:___________________________________

SUBSTANCE USE (Including alcohol, illegal drugs, nicotine, caffeine)

Please list all substances you currently use:____
____

Please list all you have used in the past:____
____

Has anyone ever expressed concern to you about your use of substances?
____
Do you have a concern regarding your use of substances? _____________________________________
____

RELIGION / SPIRITUALITY

Protestant Catholic Buddhist Hindu Jewish Muslim Atheist Agnostic Other:_____________

Are you currently active in religious or spiritual affairs? No Yes

Are you satisfied with your current level of religious or spiritual activity? No Yes

SAFETY

Have you ever had serious thoughts of suicide or homicide? No Yes

Have you ever made a suicide / homicide attempt? No Yes Explain:_________________

Do you presently feel suicidal or homicidal? No Yes Explain: ______________________
What kind of treatment have you previously had for emotional problems?

MENTAL HEALTH TREATMENT HISTORY

Individual or group therapy: How long? _________ During what year(s)? _________
Inpatient hospitalization: How long? ______ During what year(s)? ________

Are you undergoing psychotherapy treatment anywhere else now?(circle): No Yes

Briefly list your present main complaints, symptoms, and problems for which you are seeking treatment:____________________
____
____

Briefly list any additional past complaints, symptoms, and problems:____________________
____
____

Under what conditions are your problems worse? ____________________
____
____

Under what conditions are they improved?____________________
____
____

List the things you like to do most, the kinds of things and persons that give you pleasure:
____
____
____

List your main strengths: ____________________
____
____

List your weaknesses: ____________________
____
____

List your main life goals: ____________________
____
____

List the things about yourself you would most like to change:____________________
____
____

Additional information that you think might be helpful to include:
____
____
____
____
____
____