Name: _____

PRESENTING ISSUES: State briefly why you have decided to begin treatment. Indicate when you first became aware of this concern.

_____

_____

_____

_____

_____

_____

_____

_____

Check if you CURRENTLY have or experience any of the following:

- ☐ Depressed Mood
- ☐ Anxiety/Worry
- ☐ Thoughts/Actions You Cannot Control
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Belief That Others are Trying to Harm You
- ☐ Voices/Sounds Others Do Not Hear

Check if you've experienced major changes IN THE PAST MONTH in any of these areas of life:

- ☐ Sleep
- ☐ Decisiveness
- ☐ Anxiety/Worry
- ☐ Appetite
- ☐ Frustration
- ☐ Motiviation
- ☐ Concentration
- ☐ Interest in Sex
- ☐ Anger
- ☐ Suicidal **Thoughts**
- ☐ Memory
- ☐ Risk-Taking
- ☐ Sadness
- ☐ Spending
- ☐ Violent Thoughts
- ☐ Obsessive Thoughts/Rituals

Describe: _____

_____

_____

_____

_____

_____

Ethnicity: _____

Religion: _____

Referred By: _____

PRIOR THERAPY:

Name of Clinician	Dates	Comments

HOSPITALIZATIONS FOR PSYCHIATRIC OR DRUG/ALCOHOL TREATMENT

Hospital/Organization	Dates	Reasons for Treatment

Check if you've experienced major changes IN THE PAST Year in any of these areas of life:

☐ Moving ☐ Death(s) in Family ☐ Traumatic Events ☐ Health/Illness (self/others)
☐ Birth(s) ☐ Relationships ☐ Job Loss/Disruption/Change ☐ Other

Describe: _____

_____

_____

_____

_____

Check if you've ever experienced any of the following AS A CHILD, TEEN, OR ADULT?

☐ Physical Abuse ☐ Verbal/Emotional Abuse ☐ Sexual Abuse
☐ Sexual Assault ☐ Alcohol/Drug Abuse ☐ Mental Illness
☐ Violence ☐ Neglect ☐ Other

Describe: _____

_____

_____

_____

_____

Has anyone in your family had a mental illness? If so, describe: _____

_____

_____

_____

_____

HEALTH STATUS:

Health/Medical Problems: _____

_____

Current Physical Symptoms: _____

_____

Date of Last Physical Exam: _____ **Reason for Exam:** _____

Significant Surgery or Hospitalizations: _____

_____

Current Medications (names, amounts): _____

_____

_____

Current Physician **Name:** _____

Address: _____

Other Health Provider **Name:** _____

Address: _____

Do you or does anyone in your life think you have a problem with ALCOHOL? ☐ **Yes** ☐ **No**

Describe: _____

_____

_____

Describe current and past history of illicit drug use: _____

_____

_____

_____

FAMILY OF ORIGIN: Please list all important people in your life as a child (biological parents, step-parents, biological siblings, step-siblings, half-siblings, and others that played a significant role in your life as a child, both positively and negatively)

Name	Relationship	Comments*

***e.g. health, unusual circumstances, difficulties in relationship, or if the person is deceased (please include date of death)**

SIGNIFICANT CURRENT RELATIONSHIPS: Describe who lives with you, friends, significant others, and the quality of these relationships.

_____

_____

_____

_____

_____

_____

_____

ARE YOU CURRENTLY AFRAID OF ANYONE IN YOUR HOUSEHOLD? YES NO

If yes, please describe? _____

_____

Any problems with development as a child? If yes, describe developmental milestones and delays:

_____

_____

_____

EDUCATION:

Describe what kind of student you are/were in school (academic and social difficulties):

_____

_____

EMPLOYMENT:

Describe your employment history, especially significant events and difficulties:

_____

_____

LEGAL HISTORY:

Describe any arrests, sentencing, DUI occurrences, incarceration, or litigation:

_____

_____

GOALS: What do you want from counseling?

_____

_____

_____

_____

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