





**Previous Treatment**

Have you received or participated in previous counseling and/or therapy?  Yes  No

Additional Information: \_\_\_\_\_

Have you had hospital stays for psychological concerns?  Yes  No

Additional Information: \_\_\_\_\_

List any current, or important past, medications

Medication & Dose	Date	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently experiencing thoughts of harming either yourself or someone else?  Yes  No

Have you in the past experienced thoughts of harming either yourself or some one else?  Yes  No

**Developmental History**

Are you aware of any difficulties or complications during the time your mother was pregnant with you?  Yes  No

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

Did you walk, talk, and read on time?  Yes  No, explain: \_\_\_\_\_

**Medical History**

History of serious childhood illnesses : \_\_\_\_\_

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: \_\_\_\_\_

Have you experienced any head injuries?  Yes  No Important Details: \_\_\_\_\_

If yes, did you lose consciousness?  Yes  No

Have you experienced convulsions or seizures?  Yes  No If yes, did you also have a fever?  Yes  No

Explain any allergies you have: \_\_\_\_\_

How would you rate your current physical health?  Excellent  Very Good  Good  
 Fair  Poor  Very Poor

What was the date of your last physical or routine health "check up?" \_\_\_\_\_

Do you have a primary care physician?  Yes  No If yes complete the following:

_____	_____	_____
Name	Address	Phone

**Family History**

Birth Location \_\_\_\_\_ Raised by:  Mother  Father  Step-Mother  Step-Father  
 Other: \_\_\_\_\_

Relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

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

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

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? \_\_\_\_\_

Any family history of substance abuse, mental illness, suicide, or violence? \_\_\_\_\_

Any Additional Family Information: \_\_\_\_\_

### Social History

Describe your relationship with peers and/or friends.? \_\_\_\_\_

How would you describe your social support network? \_\_\_\_\_

Describe your hobbies/interests: \_\_\_\_\_

Have you ever had concerns about being too "shy" or "timid"; or too "rambunctious" or "loud" socially? \_\_\_\_\_

Describe any cultural concerns: \_\_\_\_\_

What is your religious/spiritual background? \_\_\_\_\_

Do you wish to integrate religious/spiritual material as part of treatment?  Yes  No

### Educational History

- When attending school where you :  In regular classes  
 Home Study  
 Special classes: \_\_\_\_\_  
 Ever suspended: \_\_\_\_\_

What is the highest educational level you have completed? \_\_\_\_\_

Give any additional important educational information (i.e. Did you like school?): \_\_\_\_\_

### Occupational History

What is your current employment status?  Employed Full-Time  Employed Part-time  Unemployed  
 Self-employed  Student

If employed, who is your employer? \_\_\_\_\_ What is your position: \_\_\_\_\_

How would you describe your job satisfaction:  Poor  Fair  Good  Great

How would you describe your job performance:  Poor  Fair  Good  Great

What type of employment or training have you had previous to your current occupation? \_\_\_\_\_

### Marital History

Which best describes your marital status?  Married, Date: \_\_\_\_\_  Never Married  Widowed, Date: \_\_\_\_\_  
 Separated, Date: \_\_\_\_\_  Divorced, Date: \_\_\_\_\_

If you are married please briefly describe nature of your marital relationship: \_\_\_\_\_

If you are married, which best describes your marital satisfaction?  Poor  Fair  Good  Great

Please list any previous marriages/significant relationships including current:

First Name	Dates	Nature of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have children?  Yes  No If yes, complete the following?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there presently any child custody issues involving you or your family?  Yes  No

**Substance Abuse History**

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

Yes  No Additional Information: \_\_\_\_\_

**Legal & Military History**

Are you presently, or have you previously served in the military?  Yes  No If yes complete the following:

Do you currently have any pending criminal charges?  Yes  No

Have you ever been convicted of a crime?  Yes  No: If yes explain: \_\_\_\_\_

Does your family currently have Division of Family Services Involvement?  Yes  No

If yes please complete the following:

DFS Case Worker's Name : \_\_\_\_\_ Phone: \_\_\_\_\_

**Additional Information**

Summarize your goals for counseling/therapy: \_\_\_\_\_

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible? \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date