



Client Name: \_\_\_\_\_

**Employment Status:**

employed  employed/Student  student  unemployed

Your Employer's Name \_\_\_\_\_

Are you satisfied in your current job? Yes / No

Please Explain: \_\_\_\_\_

What are your means of support?

self employed  full time/part time work  parents  unemployment  Retired

spouse  other: \_\_\_\_\_

**Education:**

Please indicate your current standing:

did not graduate High School  high School Diploma  GED  some college

associates/bachelors degree  masters degree  doctorate degree

Did you have any behavioral or learning issues? Yes / No

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

Are you satisfied with your education? Yes/No, if no, please explain \_\_\_\_\_

**Residence Situation:**

lives with parents  lives with significant other  lives with spouse  lives alone

other \_\_\_\_\_

**Marital Status:  Single  Married  Divorced  Widowed  Partner**

**Family Composition** (number of siblings, parents, children, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If any siblings are deceased, indicate name. and age at death \_\_\_\_\_

**Primary Language** \_\_\_\_\_

**Religion**  Catholic  Protestant  Jewish  Hindu  Other: \_\_\_\_\_

How important are your Religious/Spiritual Beliefs:

very Important  somewhat important  not important

Would you like to talk to your therapist about your religious/spiritual beliefs? Yes / No

**Race**  Caucasian  African-American  Native American

Asian-American  Other: \_\_\_\_\_

**Ethnicity**  Hispanic  Other (be specific) \_\_\_\_\_

Would you like to talk to your therapist about any racial/cultural issues? Yes / No

Place of Birth \_\_\_\_\_

**Behavioral Health Treatment History:**

Have you ever seen a behavioral health care provider before? Yes / No

Client Name: \_\_\_\_\_

If yes, inpatient or outpatient?

\_\_\_\_\_

If yes for Inpatient, Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Length of Stay: \_\_\_\_\_ Number of admissions: \_\_\_\_\_

If yes for Outpatient, Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Therapist: \_\_\_\_\_

What type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker

( ) Other: \_\_\_\_\_

When did you see the therapist and for what reason:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medication History:

#### Allergies to Medications:

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

If you have additional allergies, please check here ( \_\_\_\_\_ ) and continue on reverse

What medications do you know you should not take? \_\_\_\_\_

What medications do you know you should not discontinue to use? \_\_\_\_\_

What herbal remedy are you currently taking? \_\_\_\_\_

Please list all medications you are **currently** on or have taken in the **last year** (prescription and over-the-counter):

Name of Medication Dosage How taken When started? Why are you taking? Dr. who prescribed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who has been prescribing the medications listed above?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Client Name: \_\_\_\_\_

**Current General Health Status:**

Please describe your current general health:

( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor

Are you feeling any physical pain at this time? Yes / No

If yes please explain: \_\_\_\_\_

\_\_\_\_\_

Please check all of the following physical conditions that apply to you now, or in the past.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Trouble sleeping    |
| <input type="checkbox"/> Colitis            | <input type="checkbox"/> Other           |  |

Please describe: \_\_\_\_\_

\_\_\_\_\_

Have you been exposed to any communicable diseases in the past 3 months? Yes \_\_\_ No \_\_\_

If yes, please explain \_\_\_\_\_

**Nutritional Screening:**

Have you **gained weight** or **lost weight** in the last 30-60 days? Yes / No

If yes, how much and why? \_\_\_\_\_

\_\_\_\_\_

Do you have any diet or nutritional concerns? Yes / No

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

\_\_\_\_\_

Do you have any food? Yes / No

If yes, please list which food and response to allergens:

\_\_\_\_\_

Any accidents/injuries? Yes \_\_\_ No \_\_\_, if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Substance Use:**

**Do you use Nicotine? Yes / No**

If yes,

( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco

Amount per day: \_\_\_\_\_ How long have you used? \_\_\_\_\_

Any related health problems? \_\_\_\_\_

Client Name: \_\_\_\_\_

Do you use Alcohol? Yes / No

If yes,

How often do you use? \_\_\_\_\_ How long have you used? \_\_\_\_\_

How much do you usually drink? \_\_\_\_\_

Any related health issues? \_\_\_\_\_

If any Recovery, Longest length of Sobriety: \_\_\_\_\_

Do you use any Illegal Drugs? Yes / No

If yes, what drug (s) do you use? \_\_\_\_\_

How often do you use? \_\_\_\_\_ How much do you use? \_\_\_\_\_

When was the last time you used? \_\_\_\_\_

**Medical:**

Do you feel like you need a physical exam? Yes / No

When was the last time you had a physical exam? \_\_\_\_\_

If it has been more than 12 months since your previous physical exam, you will need to see a primary care doctor.

If it has been more than 12 months since your last visit:

I will schedule an appointment with my primary care doctor.

I would like to be referred to a primary care doctor.

I refuse to see a primary care doctor.

Have you suffered from any recent or childhood illnesses/disorders, operations, and/or hospitalizations (please include dates and ages)

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any serious accidents/injuries? Yes \_\_\_\_ No \_\_\_\_, If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Head Injuries:  without loss of consciousness

with loss of consciousness

Please

explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Convulsions:  without fever  with fever

Please

explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any disabilities/Handicaps: Yes \_\_\_\_ No \_\_\_\_, If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**Abuse:**

Have you ever experienced any:

Physical Abuse

Sexual Abuse

Emotional Abuse

Abandonment/Neglect

If yes, by whom: \_\_\_\_\_

Length/Duration of abuse: \_\_\_\_\_

Client Name: \_\_\_\_\_

Was it reported to the authorities:

Yes / No Please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever physically, emotionally or sexually abused another? Yes \_\_\_\_ NO \_\_\_\_, if yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

**Family Social History:**

Name of your mother: \_\_\_\_\_ Age of mother: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Name of your father: \_\_\_\_\_ Age of father: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Biological parents are: ( ) Married ( ) Separated ( ) Divorced ( ) Other: \_\_\_\_\_

How would you describe your relationships with your family/siblings?:

( ) Excellent ( ) Good ( ) Fair ( ) Poor

Please explain: \_\_\_\_\_

**Family History:**

Please indicate **any family history** of the following:

( ) Substance Abuse: If yes, indicate who: \_\_\_\_\_

( ) Mental Illness: If yes, indicate who: \_\_\_\_\_

( ) Suicide: If yes, indicate who: \_\_\_\_\_

( ) Autism: If yes, indicate who: \_\_\_\_\_

( ) Developmental Disability, if yes who: \_\_\_\_\_

( ) ADHD: if yes, who: \_\_\_\_\_

**Social History:**

Please indicate if you have any concerns regarding:

- ( ) Peer Relationships
- ( ) Marital/Significant other
- ( ) Social Support Networks
- ( ) Hobbies/Interest
- ( ) Relationships with your children
- ( ) Custody issues
- ( ) Sexual Issues
- ( ) Money
- ( ) Job

If any concerns please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you think are your main strengths and abilities?

\_\_\_\_\_  
\_\_\_\_\_

How do you spend your leisure time:

Client Name: \_\_\_\_\_

- Alone
- With others
- About equal ( 1/2 alone, 1/2 with others)

List your hobbies, leisure interests, activities, interests, talents, etc. \_\_\_\_\_

\_\_\_\_\_

**Finances:**

Do you currently have financial problems? Yes \_\_\_\_ No \_\_\_\_, If yes, please explain:

\_\_\_\_\_

**Legal History:**

Are currently facing any pending charges or convictions? Yes / No

If yes, what for? \_\_\_\_\_

Have you ever been arrested or spent time in prison? Yes / No

Please explain? \_\_\_\_\_

Do you currently have a probation officer? Yes / No

Name of probation officer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Military History:**

Were you ever in the following organizations?

- Army  Air force  Coast Guard  Marines  Navy  None

Duty Status: \_\_\_\_\_ Discharge Type: \_\_\_\_\_ Rank: \_\_\_\_\_

**STOP! Very Important**

**\* Please sign this document while you are meeting with your therapist.**

I have reviewed and addressed all issues cited on this form with the client and/or guardian.

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

My therapist has reviewed and addressed all my concerns cited on this form with me.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Date