



DEMOGRAPHICS

Date ____/____/____

Name _____ Date of Birth ____/____/____ Age ____

Gender Female Male Other (specify) _____

Sexual Orientation Straight/Heterosexual Gay, Homosexual, Lesbian, Bisexual Other (specify) _____

Describe Your Ethnicity Hispanic (If applicable, country of origin) _____

- Decline
- Asian
- Black/African American
- Native Hawaiian/Pacific Islander
- White/Caucasian
- Other (specify) _____

Form completed by (if someone other than client) _____

If you need any more space for any of the questions below please use the blank back page.

PRIMARY REASON(S) FOR SEEKING SERVICES:

- Anger Management
- Depression
- Mental confusion
- Alcohol/drugs
- Anxiety
- Eating Disorder
- Sexual Concerns
- Addictive behaviors
- Coping
- Fear/phobias
- Sleeping problems
- Bullying

Other mental health concerns (specify): _____

FAMILY INFORMATION/PSYCHOSOCIAL HISTORY

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Significant others (e.g.), brothers, sisters, grandparents, step-relatives, half-relatives. (Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Marital Status:

- | | | | |
|------------------------------------|----------------------|---|----------------------|
| <input type="checkbox"/> Single | Length of time _____ | <input type="checkbox"/> Married | Length of time _____ |
| <input type="checkbox"/> Separated | Length of time _____ | <input type="checkbox"/> Unmarried, living together | Length of time _____ |
| <input type="checkbox"/> Widowed | Length of time _____ | <input type="checkbox"/> Divorced | Length of time _____ |
| <input type="checkbox"/> Annulment | Length of time _____ | <input type="checkbox"/> Divorce in process | Length of time _____ |

Total number of marriages _____

Assessment of current relationship (if applicable): Good Fair Poor

Parental Information:

- | | | |
|---|---|---------------------|
| <input type="checkbox"/> Parents, married | <input type="checkbox"/> Mother remarried | No. of times: _____ |
| <input type="checkbox"/> Parents have separated | <input type="checkbox"/> Father remarried | No. of times: _____ |
| <input type="checkbox"/> Parents divorced | | |

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc. _____

DEVELOPMENT

Are there special, unusual or traumatic circumstances that affected your development? Yes No

If yes, please describe: _____

History of abuse? Yes No If yes, which type(s)? Sexual Physical Verbal Emotional

Childhood issues? Neglect Inadequate nutrition Other (specify): _____

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you

Had nightmares about it or thought about it when they did not want to? Yes No

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Yes No

Were constantly on guard, watchful, or easily startled? Yes No

Felt numb or detached from others, activities, or your surroundings? Yes No

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (Please check all that apply)

- Affectionate Aggressive Avoidant Leader
- Follower Friendly Fight/argue often Outgoing
- Shy/withdrawn Submissive Other (specify): _____

Sexual dysfunction: Yes No If yes, describe: _____

Any current/history of being a sexual perpetrator? Yes No

If Yes, describe: _____

CULTURAL/ETHNIC

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If yes, describe: _____

Other cultural/ethnic information: _____

EDUCATION

Years of Education: _____ Currently enrolled in school? Yes No High school graduate/G.E.D.

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? Not Little Somewhat Very

Are you affiliated with a spiritual/religious group? Yes No If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

LEGAL

Are you involved in any active cases (traffic, civil, criminal?) Yes No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? Yes No

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason you left job
_____	_____	_____	_____

Currently employed: FT PT Temp Laid off Disabled Retired
 Social Security Student Other: _____

MILITARY

Military experience? Yes No Combat experience? Yes No
Where: _____ Branch: _____
Date drafted: _____ Date enlisted: _____ Discharge Date: _____
Type of discharge: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, travel, etc.)

Activity	How Often?	How often in the past?
_____	_____	_____
_____	_____	_____

Please check behaviors and symptoms that occur more often than you would like them to:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aggression/Anger | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mood Shift |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Elevated Mood | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring/disorganized thoughts |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual difficulties/addiction |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Chest pain/heart palpitations | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Disorientation/Dizziness | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Worrying/hopelessness |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness/withdrawing | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Memory impairment | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively:

Any additional information that would assist us in understanding your concerns or problems:

What are your goals for therapy?

Do you feel suicidal at this time? Yes No If yes, explain:

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Your reaction to overall experience	_____			
Suicidal thoughts/attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Your reaction to overall experience	_____			
Drug/alcohol treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Your reaction to overall experience	_____			
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Your reaction to overall experience	_____			
Involvement with self-help Groups (e.g., AA, AL-ANON, NA, OA)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Your reaction to overall experience	_____			

Information about family/significant others (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Tx	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Suicidal thoughts/attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug/alcohol treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Involvement with self-help Groups (e.g., AA, AL-ANON, NA, OA)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

CHEMICAL USE HISTORY

- Do you have any current/historical substance or alcohol use? Yes No If Yes:
- Have you ever felt you ought to cut down on your alcohol or substance use? Yes No
- Have people annoyed you by criticizing your alcohol or substance use? Yes No
- Have you ever felt bad or guilty about your alcohol or substance use? Yes No
- Have you ever used alcohol or substances first thing in the morning to steady your nerves or to get rid of a hangover? Yes No
- Do you smoke, vape, or chew? Yes No
- Do you use pain medication? Yes No

Please indicate below which substances you have used (if any):

- | | | | |
|---|------------------------|--|-------------------|
| <input type="checkbox"/> Alcohol | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Marijuana | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Cocaine/crack | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Meth/Amphetamine | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Heroin | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Other opiates | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Synthetics | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Inhalants | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Benzos | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Hallucinogens | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Over the counter | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Other: _____ | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |
| <input type="checkbox"/> Nicotine | _____ Age of first use | _____ # of days used in the last 30 days | _____ Amount Used |

Is there a history of Injection Drug Use? Yes No

What is the date of your most current use: _____/_____/_____ Substance _____
Amount _____ Method of Use _____ Frequency of use _____

Does your use affect your family and/or friends? Yes No If yes, describe: _____

Do you use alcohol or substances to cope with mental health issues or other stressors? Yes No

Have you increased your alcohol or substance intake in the last six months? Yes No

Does anyone in your family have current/historical alcohol or substance use? Yes No If yes, describe:

Family member: _____ Substance/Alcohol _____ Current/historical _____

Have you ever experienced withdrawal symptoms, had an adverse reaction to, or overdosed on alcohol or substances?

Yes No If yes, Withdrawal Adverse reaction Overdose

Describe: _____

Do you believe that your alcohol or substance use has created problems in your life, job, and/or relationships?

Yes No If yes, describe: _____

