

Client History

All information provided on this form is confidential and will only be released with your written permission through a signed and dated RELEASE OF INFORMATION.

Date: _____ Referred by: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Phones: _____
Home Work Cell Pager

Age: _____ Date of Birth ____/____/____ Social Security ____/____/____ Male__ Female__ TG ____

Marital Status: ___Single ___Married ___Committed Partnership ___Separated ___Divorced
___Widow(er) Spouse/Partner's Name _____ Age _____

Emergency Contact (Name, telephone, address) _____

Education: ___Grade School ___High school/GED ___College ___College Degree ___Graduate Degree
___Other

Occupation: _____

Employer (include location): _____ Years _____

Previous employer: _____ Years _____

Please describe the concerns(s) for which you are seeking help:

Have you been therapy before? ___Yes ___No ___Inpatient?
If yes, please describe issue(s) that led you to therapy:

What has been the outcome of your previous therapy experience?

Have you sought help with this before?
If yes,
When? With whom?

Family History

Family Member	Name	Age Living?	Addictions? If yes, please specify.	Emotional Problems? If yes, please specify
Mother				
Father				
Step-Parents				
Siblings: (Please list from oldest to youngest)				
Spouse/Partner (Beginning with most recent. Please note the starting/ending dates for relationships)				
Children: (Include children out of the house or from previous marriages or relationships)				

Religious Affiliation? _____

Church-Related Activities: _____

Hobbies: _____

Problem/Issue Checklist

<p>Emotional/psychological</p> <p><input type="checkbox"/> Anxiety/nervousness</p> <p><input type="checkbox"/> Indecisiveness</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty identifying feelings</p> <p><input type="checkbox"/> Minimizing other's feelings</p> <p><input type="checkbox"/> Difficulty hearing or tolerating other's feelings</p> <p><input type="checkbox"/> Frequent worry</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Angry outbursts</p> <p><input type="checkbox"/> Rage outbursts</p> <p><input type="checkbox"/> Generally unhappy</p> <p><input type="checkbox"/> Distrustful / suspicious</p> <p><input type="checkbox"/> Guilt feelings</p> <p><input type="checkbox"/> Upsetting or disturbing thoughts</p> <p><input type="checkbox"/> Grief / issues related to loss</p> <p><input type="checkbox"/> Frequent sadness</p> <p><input type="checkbox"/> Mood swings</p> <p><input type="checkbox"/> Periods of hyperactivity followed by depression</p> <p>Other _____</p>	<p>Social</p> <p><input type="checkbox"/> Fear of people</p> <p><input type="checkbox"/> Fear of crowds</p> <p><input type="checkbox"/> "Social phobic"</p> <p><input type="checkbox"/> Isolative</p> <p><input type="checkbox"/> Frequent use of Internet chat rooms</p> <p><input type="checkbox"/> Using Internet to find a relationships</p> <p><input type="checkbox"/> Meeting with people from chat rooms and/or Internet sites</p> <p><input type="checkbox"/> Is not liked by others</p> <p><input type="checkbox"/> Difficulty "fitting and"</p> <p><input type="checkbox"/> Lack of companionship</p> <p><input type="checkbox"/> Frequent loneliness</p> <p><input type="checkbox"/> Pattern of relationship problems</p> <p><input type="checkbox"/> Religious problem s</p> <p><input type="checkbox"/> Pattern of financial problems</p> <p><input type="checkbox"/> Legal problems</p> <p><input type="checkbox"/> Gambling problems</p> <p><input type="checkbox"/> Weight problems</p> <p>Other _____</p>	<p>Work-related</p> <p><input type="checkbox"/> Job stress</p> <p><input type="checkbox"/> Decline in work performance</p> <p><input type="checkbox"/> Authority problems</p> <p><input type="checkbox"/> Conflicts with supervisors</p> <p><input type="checkbox"/> Conflicts with coworkers</p> <p><input type="checkbox"/> Absenteeism</p> <p><input type="checkbox"/> Chronic tardiness</p> <p><input type="checkbox"/> Pattern of frequent job changes / layoffs / firings</p> <p><input type="checkbox"/> Frequently bored with job</p> <p><input type="checkbox"/> Using Internet at work to cope with boredom</p> <p><input type="checkbox"/> Grievances / EEOC claims</p> <p><input type="checkbox"/> Sexual harassment</p> <p><input type="checkbox"/> Excessive workload</p> <p><input type="checkbox"/> Excessive time pressures</p> <p><input type="checkbox"/> Job jeopardy due to behavior</p> <p>Other _____</p>
<p>Relationship problems</p> <p><input type="checkbox"/> Pattern of difficulty in establishing relationships</p> <p><input type="checkbox"/> Avoidance of relationships</p> <p><input type="checkbox"/> Pattern of getting "too close to soon" in relationships</p> <p><input type="checkbox"/> Difficulty leaving relationships (feeling guilty, a disloyal, "bad", etc.)</p> <p><input type="checkbox"/> Relationships characterized by chaos and turmoil</p> <p><input type="checkbox"/> Difficulty tolerating time between relationships</p> <p><input type="checkbox"/> Pattern of picking unavailable people</p> <p><input type="checkbox"/> Pattern of picking abusive men / women as relationship partners</p> <p><input type="checkbox"/> Pattern of abusive behavior torn relationship partners</p> <p><input type="checkbox"/> Neglecting friends while in relationships</p> <p><input type="checkbox"/> Neglecting sell while in relationships</p> <p><input type="checkbox"/> Pattern of "giving up" or "losing yourself" in relationships</p> <p><input type="checkbox"/> Confusing love with intensity</p> <p><input type="checkbox"/> Believing sex equals love</p> <p><input type="checkbox"/> Difficulty identifying and/or stating your needs and wants</p> <p><input type="checkbox"/> Childhood family history of abusive / neglectful behavior</p> <p><input type="checkbox"/> Currently / recently acting in abusive / neglectful manner in relationship</p> <p><input type="checkbox"/> Idealizing past relationships while neglecting / avoiding current relationship</p> <p>Other _____</p>		<p>Health Medical</p> <p><input type="checkbox"/> Chronic medical problems</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Sleep disturbance</p> <p><input type="checkbox"/> Recent wait all gains / losses</p> <p><input type="checkbox"/> Family history of health problems</p> <p><input type="checkbox"/> More than one year since last medical checkup</p> <p><input type="checkbox"/> More than one year since last dental checkup</p> <p><input type="checkbox"/> Currently taking prescribed medications? If yes, please list. (Include prescribing physician.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Alcohol Use</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Other</p>	<p>Drug Use</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Other</p>	
<p>Addictive / Compulsive Behavior</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have family/friends ever express concern over use of alcohol, drugs, sex, money, food, gambling etc.?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been arrested for any offense involving alcohol, drugs, sex, gambling, money, etc., including DWI?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been in treatment for alcohol, drug and/or sexual dependency, gambling, food, etc.?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Do you think you are a Normal drinker?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever attended a 12 step meeting? (Please circle: AA, Al-anon, CA, NA, SLAA, SAA, OA, GA, CoDa, etc.)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt like certain addictive / compulsive behaviors are running your life?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever neglected responsibilities (of any kind) because an addictive / compulsive behavior?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever lost relationships with family, friends, spouses / partners, children due to addictive / compulsive behavior?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever made promises to stop problem behaviors but were unable to keep your promises (including to yourself)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever continue problematic behavior despite adverse consequences to self and/or others?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Are there activities and/or behaviors that you keep hidden or secret from others including family and friends?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt like you were out of control regarding your behavior and/or alcohol / drug use?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Has your behavior and/or alcohol / drug use ever caused you to violate your personal values?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt like you were living a double life—that even those closest to you didn't really know you?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt that if people closest to you knew the full story (i.e., your secrets) they'd leave you?</p>		