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Client Information – How I Can Help

Note: If you were a client here before, please fill in only the information that has changed.

Date _____

Client Identification

Your name: _____ Date of birth: _____

Your preferred name(s): _____ Preferred pronoun: _____

Chief concern

Please describe the main reason for seeking treatment with me: _____

_____

_____

_____

_____

What goals do wish to achieve during therapy? _____

_____

_____

What helped you decide to start therapy? _____

_____

_____

Mental Health Treatment History

Have you received outpatient counseling in the past for this or a different problem? ..... ☐ **Yes** ☐ **No**

*** If yes, please answer the following questions:**

Provider	Dates of Treatment	Diagnosis(es)	Was Treatment Helpful?
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**

Have you taken or are you currently taking medication for mental health care? ..... ☐ **Yes** ☐ **No**

*** If yes, please answer the following:**

Provider	Date of Treatment	Medication(s)/Dosage(s)	Was Treatment Helpful?
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**

Have you ever received ***inpatient*** treatment for psychological, emotional, or substance abuse problems?
* **If yes, please answer the following questions:** ..... ☐ **Yes** ☐ **No**

Inpatient Facility	Date of Treatment	Diagnosis(es)	Was Treatment Helpful?
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**
_____	_____	_____	☐ **Yes** ☐ **No**

Have you ever attempted suicide? ..... ☐ **Yes** ☐ **No**

If yes, how did you attempt; date of last attempt: _____

Have you ever engaged in non-suicidal self-injury? ..... ☐ **Yes** ☐ **No**

If yes, what type of self-injury; date of last event: _____

Have you ever attempted to intimidate, harm or otherwise aggress against another person that resulted in negative consequences legally or interpersonally? ..... ☐ **Yes** ☐ **No**

If so, please explain: _____

_____

_____

Do any of your immediate or extended family have psychological, emotional, or substance abuse problems? ..... ☐ **Yes** ☐ **No**

If yes, please provide additional information: _____

_____

_____

Has any family member or close friend attempted or completed suicide? ..... ☐ **Yes** ☐ **No**

If yes, who and when? _____

_____

Relationships in your family of origin. (Please describe the following):

Please tell me about your **parents/step-parents**:

Names	Ages	Relationship to You	Education	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please tell me about your **siblings/step-siblings**:

Names	Ages	Relationship to You	Education	Occupation

Please describe your parents' relationship with each other: _____

_____

_____

Please describe your relationship with each parent and/or with other adults present in your family: _____

_____

_____

Please describe your parents' physical health problems, chemical use, and mental or emotional difficulties:

_____

_____

Please describe your relationship with your siblings, in the past and present:_____

_____

_____

Trauma History

Do you have a history of trauma? ……☐ **Yes** ☐ **No**

If yes, please describe or indicate if you prefer to talk about it first: _____

_____

_____

Abuse history – Did you experience:

Physical abuse ☐ Sexual abuse ☐ Emotional abuse ☐ Unwanted touch ☐ Neglect ☐

Did you experience this as a: Child ☐ Adolescent ☐ Adult ☐

I experienced no abuse or neglect ☐

If yes, please describe? _____

_____

_____

Current Relationship

Are you in a relationship now? ..... ☐ **Yes** ☐ **No**

Name of person with whom you are in a relationship: _____

How do you get along with your present spouse or partner? _____

_____

_____

Do you have any children? ..... ☐ **Yes** ☐ **No**

*** If yes, please, please list their name and age(s)**

Name	Age	School/Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How do you get along with your children? _____

_____

_____

Medical History

Do you have any medical issues/problems that require regular contact with a physician? ... ☐ **Yes** ☐ **No**

If yes, please describe: _____

_____

Do you take medications for non-psychiatric reasons? ..... ☐ **Yes** ☐ **No**

If yes, please list: _____

_____

Do you see your medical provider as directed? ..... ☐ **Yes** ☐ **No**

Approximately when was your last physical exam? _____

Do you exercise regularly? ..... ☐ **Yes** ☐ **No**

Do you have allergies? ..... ☐ **Yes** ☐ **No**

Are you allergic to dogs or cats? ..... ☐ **Yes** ☐ **No**

Do you have a fear of dogs? ..... ☐ **Yes** ☐ **No**

Do you have physical limitations that make going up and down stairs difficult? ..... ☐ **Yes** ☐ **No**

Chemical use

Have you ever felt the need to cut down on your drinking? ..... ☐ **Yes** ☐ **No**

Have you ever felt annoyed by criticism of your drinking? ..... ☐ **Yes** ☐ **No**

Have you ever felt guilty about your drinking? ..... ☐ **Yes** ☐ **No**

Have you ever taken a morning "eye-opener"? ..... ☐ **Yes** ☐ **No**

How much beer, wine, or hard liquor do you consume each week, on the average? _____

_____

Which drugs (not medications prescribed for you) have you used in the last **10 years**?

Substance	Age First Used	Age Last Used	Current Use	Frequency	Amount
Alcohol			☐ Yes ☐ No		
Amphetamines			☐ Yes ☐ No		
Barbiturates			☐ Yes ☐ No		
Caffeine			☐ Yes ☐ No		
Cocaine/Crack			☐ Yes ☐ No		
Ecstasy			☐ Yes ☐ No		
Hallucinogens			☐ Yes ☐ No		
Inhalants			☐ Yes ☐ No		
Marijuana/Hash			☐ Yes ☐ No		
Nicotine/Tobacco			☐ Yes ☐ No		
Opioids			☐ Yes ☐ No		
PCP			☐ Yes ☐ No		
Prescription			☐ Yes ☐ No		
Other			☐ Yes ☐ No		

Have you experienced any negative consequences due to substance use (e.g., withdrawal, blackouts, legal problems, relationship conflicts, financial problems)?..... ☐ **Yes** ☐ **No**

If yes, please describe: _____

_____

Social History

What are your hobbies? _____

_____

What are your strengths? _____

_____

How do you cope with challenges, now or in the past? _____

_____

Do you, or have you in the past, had legal problems? ..... ☐ **Yes** ☐ **No**

If yes, please describe: _____

_____

How would you describe your current support system? _____

_____

What would you describe as barriers or roadblocks to treatment? _____

_____

Do you engage in any behaviors that cause problems in your current relationships, at work or school, or other major areas of your life? _____

_____

Describe your spiritual/religious beliefs and practices: _____

_____

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____

_____

_____

_____

Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, under-eating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection

- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-injury
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Trauma
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

- ☐ _____
- ☐ _____

Please look back over the concerns you have checked off and choose the one or two that you **most** want help with. They are:

_____

_____