Paso Robles Counseling & Therapy

Where Healing Happens…

Client History

Client's Name:_____________________________________

Who is providing the history information?

[ ] Client [ ] Client's guardian [ ] Other

Please describe the current complaint or problem as specifically as you can.

____

How long have you experienced this problem, or when did you first notice it?

____

What stressors may have contributed to the current complaint or problem?

____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence [ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)

[ ] Depression/Sad/Down feelings [ ] High/Low energy level [ ] Angry/Irritable [ ] Physical Abuse

[ ] Loss of interest in activities [ ] Difficulty enjoying things [ ] Crying spells [ ] Emotional Abuse

[ ] Decreased motivation [ ] Withdrawing from people/Isolation [ ] Sexual Abuse

[ ] Mood Swings [ ] Black and white thinking/All or nothing thinking

[ ] Negative thinking [ ] Change in weight or appetite [ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself [ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting [ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness [ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem [ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks [ ] Racing or scrambled thoughts [ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares [ ] Muscle tensions, aches, etc. [ ] Hearing voices/seeing things not there

[ ] Thoughts of running away [ ] Paranoid thoughts/Thoughts someone is watching you, out to get you or hurt you

[ ] Feelings of frustration [ ] Feelings of being cheated [ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting [ ] Feelings of loss of control over eating [ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating [ ] Excessive exercise [ ] Indecisiveness about career

[ ] Job problems [ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy?

[ ] Yes [ ] No

What did you like/dislike about previous treatment?

____

What did you learn about yourself through previous counseling/treatment that may help you?

____

Is there any type of treatment you would like to continue?

____

Have you had hospital stays for psychological concerns (72 hour hold)?

[ ] Yes [ ] No

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 someone 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 If no, explain: ____

History of serious childhood illnesses: ____

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

____

Are you satisfied at where you are in your life? If not, where would you like to be?

______________________________________, ________________________________

Medical History

List any current or important past medications

Medication(s) & Dose: _______________________________

Response to Medication:______________________________

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: age:______________ length:________________________________

Have you experienced any head injuries/ loss of consciousness: [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] 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 exam? ___________________

Do you have a primary care physician? [ ] Yes [ ] No

Name: ____________________ Address: ___________________ Phone Number: __________

Family History

Place of Birth: _________________________________

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other:

Relationship with parent figures:

(good, fair, poor, close, distant, etc.)

Mother:_________ Father: _______ Step-parent: ________ Other: _________

Siblings: brothers: _______ sisters: _________

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

(circle those that apply)

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

(circle those that apply)

Social History

Describe your relationship with peers and/or friends? _________________________________

How would you describe your social support network? ________________________________

Describe your hobbies/interests: ____

Educational History

When attending school were you:

[ ] In regular classes [ ] Home Study [ ] Special classes

[ ] Advanced classes [ ] Ever suspended [ ] Placed in alternative school

What is the highest educational level you have completed? _____ Degree: _______

Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed [ ] Self-employed

[ ] Student [ ] Other

Are you satisfied with your employment? ___________ If not, why? _____________________

Marital History

Which best describes your marital status?

[ ] Married, Years: ______ [ ] Never Married [ ] Widowed, Date: _____________

[ ] Separated, Date: _____________ [ ] Divorced, Date:______________

If you are married, which best describes your marital satisfaction?

[ ] Poor [ ] Fair [ ] Good [ ] Great

Do you have children? [ ] Yes [ ] No

Boys:_______ ages: Girls: _______ ages:

Are there presently any child custody issues involving you or your family?

[ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No

If yes please complete the following: Case Worker's Name: ______________________

Phone: _________________________________

Substance Abuse History

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

[ ] Yes [ ] No

If you answered yes, please complete the following substance abuse history information.

Substance(s): ____

Age of First Use:______ Frequency of Use: (Daily, Weekly, Monthly) ____________________

Amount Used:_________ How did you use it? (smoked, injected, etc.): ___________________

Alcohol ____ Marijuana ____ Cocaine or Crack ____ Heroin ____ Amphetamines ____

Club Drugs (Ecstasy, Inhalants, etc.) ____ Pain Medication (Oxycontin, Vicodin, etc.) ____

Benzodiazepines ____ Hallucinogens____ Other ____

Complete the following if you have ever received treatment for a substance abuse issue.

Name of Treatment Program: ______________________________

Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)

Date of Treatment (Month, Year): ______________________

Outcome (Any Clean time?): ___________________________

Legal History

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No:

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Are you on probation? [ ] Yes [ ] No

Name of Probation Officer and County; ____

List dates of any Arrests/Convictions: ____

Outcome:(Served time, Community Service, Drug/Alcohol Treatment, etc.) ____________

Treatment Goals

Summarize your goals for counseling/therapy:

____

What expectations do you have for counseling/therapy?

____

Name 5 things you would like to change about yourself:

____

What are your strengths?

____

What are your weaknesses?

____

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

____

____

_________________________________ _________________________________

Signature of client/guardian Date