Counseling Associates for Well-Being

Client Information

Please complete the following questions to the best of your ability. This information is confidential.
They are intended to assist us in providing the most informed care.

Client Name_____ Age: _____

In your own words briefly describe the main reason you are here for care.

What are you hoping that you will accomplish and how long are you expecting to be in therapy/counseling?

Family Information:

Spouse/Partner's name: _____

If married, for how long? _____ If divorced/separated, for how long? _____ Number of marriages: _____

Previous spouse/ partner's name/s: _____

What was your age when you first married? _____

How many children do you have? _____ Step or other children in your life: _____

Please list your children's names and ages:

What are your parents' names? _____

Parents' marital status? _____ If divorced, your age when they divorced? _____

If divorced did they remarry? _____ What was your age when they remarried? _____

What are their ages if living? Mother _____ Father _____

What was their age at death if deceased? Mother _____ Father _____

Father's occupation: _____ Mother's occupation: _____

Names/ relationships of any other significant caretakers in your life growing up _____

How many siblings (biological, adopted, step, half, and other) do you have? _____

Please list their names and ages:

Do any blood relatives of yours have any mental health or substance abuse problems? _____

Please describe:

Health Information

Please provide the name, address and, phone number of your Primary Care Physician (if you have one):

Name:_____ Phone: _____

Address: _____

Please list any medical problems or conditions for which you are currently being treated:

Current Medications (prescription, herbal or over the counter)**:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Please list any medications you have taken in the past that were prescribed to alleviate mental health symptoms:

Have you previously received any counseling, psychotherapy or psychiatric care? _____
Please describe (when, what kind, by whom):

Have you ever been hospitalized: _____ When? _____
For what?

Any history of suicide attempts: _____ When? _____
Describe:

Personal Information

Name three words to describe yourself: _____

Name three words to describe your Father: _____

Name three words to describe your Mother: _____

Name three words to describe your spouse/partner: _____

Name three words to describe the family you grew up in: _____

Sexual & Gender Identity:

☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Asexual ☐ In Question ☐ Other

Who lives in your household with you currently (names, ages, relationship)?

Briefly describe your level of social support/ friends:

Is spirituality important in your life?
If so, explain :

Please briefly describe any recent significant life events (ie; death in the family, loss of job, recent move, etc):

Have you ever been physically, emotionally, or sexually abused by anyone? -
Please briefly describe as much as you are comfortable:

Please describe any legal issues (for example custody, probation for DUI, assault etc.) you are currently or have previously been involved in:

Please describe your usage of alcohol and/or drugs (current or past):

Do you smoke or use tobacco? - If YES, how much per day?

Do you consume caffeine? - If YES, how much per day?

Do you drink alcohol? _ If YES, how much per day/week/month/year?

Do you use non-prescription drugs? _ If YES, what kinds and how often?

Have any of your friends or family members voiced concerns about your substance abuse? -

Have you ever been in trouble or risky situations because of your substance abuse? -

Have you experienced any traumatic events? - Describe as much as you feel comfortable:

Do you consider yourself to have a healthy relationship with food?

Describe:

Current Occupation: How Long?: Rate your level of employment satisfaction (1-10):

What diagnosis or condition, if any, that you know about do you think might apply to you?

PLEASE CHECK ALL THAT APPLY:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →	☐	☐	People in General →	☐	☐	Nausea →	☐	☐
Depression	☐	☐	Parents	☐	☐	Abdominal Distress	☐	☐
Mood Changes	☐	☐	Children	☐	☐	Fainting	☐	☐
Anger or Temper	☐	☐	Marriage/Partnership	☐	☐	Dizziness	☐	☐
Panic	☐	☐	Friend(s)	☐	☐	Diarrhea	☐	☐
Fears	☐	☐	Co-Worker(s)	☐	☐	Shortness of Breath	☐	☐
Irritability	☐	☐	Employer	☐	☐	Chest Pain	☐	☐
Concentration	☐	☐	Finances	☐	☐	Lump in the Throat	☐	☐
Headaches	☐	☐	Legal Problems	☐	☐	Sweating	☐	☐
Loss of Memory	☐	☐	Sexual Concerns	☐	☐	Heart Palpitations	☐	☐
Excessive Worry	☐	☐	History of Child Abuse	☐	☐	Muscle Tension	☐	☐
Feeling Manic	☐	☐	History of Sexual Abuse	☐	☐	Pain in joints	☐	☐
Trusting Others	☐	☐	Domestic Violence	☐	☐	Allergies	☐	☐
Communicating with Others	☐	☐	Thoughts of Hurting Someone Else	☐	☐	Often Make Careless Mistakes	☐	☐
Drugs	☐	☐	Hurting Self	☐	☐	Fidget Frequently	☐	☐
Alcohol	☐	☐	Thoughts of Suicide	☐	☐	Speak Without Thinking	☐	☐
Caffeine	☐	☐	Sleeping Too Much	☐	☐	Waiting Your Turn	☐	☐
Frequent Vomiting	☐	☐	Sleeping Too Little	☐	☐	Completing Tasks	☐	☐
Eating Problems	☐	☐	Getting to Sleep	☐	☐	Paying Attention	☐	☐
Severe Weight Gain	☐	☐	Waking Too Early	☐	☐	Easily Distracted by Noises	☐	☐
Severe Weight Loss	☐	☐	Nightmares	☐	☐	Hyperactivity	☐	☐
Blackouts	☐	☐	Head Injury	☐	☐	Chills or Hot Flashes	☐	☐

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems	☐	Physical Abuse	☐	Depression	☐
Legal Trouble	☐	Sexual Abuse	☐	Anxiety	☐
Domestic Violence	☐	Hyperactivity	☐	Psychiatric Hospitalization	☐
Suicide	☐	Learning Disabilities	☐	"Nervous Breakdown"	☐

Which of these is the main problem?:

Any additional information you would like to include: