HERSTORY/HISTORY

Today's Date:_____ Referral Source:_____

Name _____

Address_____

City _____ State_____ Zip Code _____

Phone (Home) _____ Phone (Cell)_____

May I leave a message at either of these numbers? _____

Email Address _____ Birth Date_____

Are you planning to submit my bills to your insurance company for reimbursement? _____

Present situation

Please state why you decided to come for counseling at this time.

_____

What is the nature of your situation?

_____

_____

What have you tried in the past to address this issue?

_____

_____

How long has this been a problem for you?_____

Please state what you would like to work on in therapy.

_____

_____

Work history

Occupation _____ How long _____

If presently unemployed, describe the situation_____

_____

Hobbies/Passions _____

What three words would you use to describe:

Yourself: _____ _____ _____

Your Father: _____ _____ _____

Your Mother _____ _____ _____

God: _____ _____ _____

Spiritual History

Religious upbringing _____ Present Affiliation _____

Is this an important part of your life? _____ Why/Why not? _____

Physical/Mental Health History

General Health _____

Any recurrent or chronic conditions?_____

Are you taking any medication?_____ If yes, lease list:

Type of medication Reason for medication How long have you been taking it

_____

_____

_____

How many hours per night do you sleep? _____ Do you wake up in the night? _____

Do you drink alcohol?_____ If yes how often/how much? _____

Do you use drugs?_____ If yes, what and how often?_____

Have you ever been hospitalized for a mental illness?_____ Describe_____

_____

Have you ever received treatment for alcohol and/or drugs? _____ Describe_____

_____

Any previous counseling/therapy?_____ If yes, when was it, for how long, and what was the result?

_____

_____

Family Information

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as patient:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation with above : _____

Parents:

Father alive _____ Where residing? _____ Relationship _____

Mother alive _____ Where residing? _____ Relationship _____

Parents divorced? _____ If yes, your age at that time _____

If deceased, your age at the time _____ Cause of death _____

Any step-parents? _____ If yes, describe your relationship with them _____

_____

Family Alcoholism or Domestic Violence? _____ Sexual Addiction or Abuse? _____

Siblings:

First name	Age	Relationship (also please indicate if they are deceased)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you married? _____ # of marriages _____ Spouse's name _____

Living with a partner? _____ How long? _____ Partner's name _____

Are you in an intimate relationship right now?_____ Please describe any past or current significant issues in intimate relationships.:_____

_____

_____

Describe any past or current significant issues in other immediate family relationships:_____

_____

_____

Please tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

Emotional status

Please respond to each of the following symptoms by indicating in the boxes provided how much of a problem they have been in the last 2 weeks using the following scale:

1 - Serious problem 2- Moderate problem 3 - Minor problem 4 - Not a problem

_____ depressed mood
_____ compulsive behavior
_____ anger
_____ increased appetite
_____ decreased appetite
_____ problems with sleep
_____ poor judgement
_____ excessive worry
_____ elimination disturbance
_____ fatigue/low energy
_____ slow movements
_____ poor concentration
_____ mood swings
_____ agitation
_____ emotionality
_____ irritability
_____ generalized anxiety
_____ panic attacks
_____ phobias
_____ binging/purging
_____ laxative/diuretic use
_____ anorexia
_____ paranoid ideas

_____ substance abuse
_____ overly detailed thoughts
_____ jumping from topic to topic
_____ delusions
_____ hallucinations
_____ hearing voices
_____ aggressive behavior
_____ conduct problems
_____ oppositional behavior
_____ sexual dysfunction
_____ grief
_____ hopelessness
_____ social isolation
_____ worthlessness
_____ guilt
_____ elevated mood
_____ hyperactivity
_____ losing track of time or place
_____ physical complaints
_____ self mutilation
_____ significant weight loss/gain
_____ nightmares
_____ flashbacks

_____ compulsive sexual behavior
_____ compulsive spending
_____ gambling
_____ excessive clutter in home
_____ thoughts of death/suicide
_____ loss of interest (in things you once enjoyed)
_____ a medical condition
_____ emotional trauma victim
_____ physical trauma victim
_____ sexual trauma victim
_____ emotional trauma perpetrator
_____ physical trauma perpetrator
_____ sexual trauma perpetrator

Have you had any thoughts of suicide? _____ Do you have any thoughts now? _____

Thank you for completing this form.