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Client History

Thank you for taking the time to fill out this form. This detailed history will assist in creating appropriate treatment goals for you in addition to maximizing your time within the therapy session.

Name:_____ Birth Date: ____/ _____/_____ Age:_____

What are the main concerns or issues that are bringing you to therapy at this time?

_____

_____

What are the main goals you would like to accomplish in therapy? _____

_____

_____

What qualities are most important to you in a therapist? _____

_____

Are you currently receiving counseling or psychiatric services elsewhere? Yes No

With Whom and for what reason?_____

Have you received counseling or psychiatric services in the past? Yes No

With whom, when, and for what reason?_____

_____

Please describe your level of satisfaction with past treatment. What helped and what didn't?

_____

_____

Please list name and dosage of current prescribed psychiatric medications or herbs?_____

_____

_____

HEALTH AND SOCIAL INFORMATION:

How is your health at present? |__|__|__|__|__|__|__|__|__|__|
1 5 10
Very poor Excellent

Please list any persistent physical symptoms or health concerns:_____

_____

How is your sleep? |__|__|__|__|__|__|__|__|__|__|
1 5 10
Very poor Excellent

Check where applicable: ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ Other_____

How often do you exercise? _____

What type of physical activity do you engage in? _____

Please check the box that describes your participation in the following:

	Daily	Weekly	Monthly	Rarely	Never Amount
Alcohol	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Prescription Medication	☐	☐	☐	☐	☐
Other drugs	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐
Diet sodas	☐	☐	☐	☐	☐
Gambling	☐	☐	☐	☐	☐
Television	☐	☐	☐	☐	☐
Internet	☐	☐	☐	☐	☐
Pornography	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

Please describe any other behaviors or activities that you are concerned about: _____

_____

_____

_____

Are you currently in a romantic relationship? _____ How long? _____

Name _____ Age _____ Gender _____

How would you rate the quality of your relationship? |__|__|__|__|__|__|__|__|__|__|
1 5 10
Very poor Excellent

How would you rate the quality of your communication? |__|__|__|__|__|__|__|__|__|__|
1 5 10
Very poor Excellent

How would you rate your level of satisfaction with the sexual aspect of your relationship?
|__|__|__|__|__|__|__|__|__|__|
1 5 10
Very dissatisfied Very satisfied

Do you have children? Yes No

Names and ages of children: _____

_____

_____

Your mother's name: _____ Occupation:_____ Living Deceased

Describe this relationship: _____

Your father's name: _____ Occupation: _____ Living Deceased

Describe this relationship: _____

Please describe your parent's marital history: _____

Step parent's names: _____

Describe this relationship: _____

What are the names, ages, and geographic location of your siblings? _____

_____

Adoptions? _____ Deaths?_____

Other significant family members or people in your life? _____

Place of Birth: _____

Please describe your childhood: _____

_____

How would you describe your support system? _____

_____

What is your highest level of education? _____

Have you ever been told you have a learning disability or gift? Please explain:

_____

Please describe your educational experience including academic, social or anything that stands out for you: _____

_____

Academic goals? _____

Are you currently employed? _____ Employer/position _____

Past employment: _____ Career goals? _____

Rate your current level of job satisfaction |__|__|__|__|__|__|__|__|__|__|
1 5 10
Very poor Excellent

Please describe any work-related stressors _____

_____

How important is religion or spirituality in your life? |__|__|__|__|__|__|__|__|__|__|
1 5 10
Not at all Very important

Please describe _____

What do you like to do in your free time (hobbies, activities, sports etc.)? _____

_____

In the last year, have you experienced any significant life changes, losses or stressors in the following areas?
☐ Work ☐ Relationship ☐ Financial ☐ Health ☐ Family ☐ Housing ☐ other _____

Please describe _____

_____

Do you have loss, trauma, or unresolved grief? Please explain: _____

_____

Have you ever experienced:

☐ extreme depressed mood	☐ alcohol/substance abuse	☐ unexplained loss of time
☐ rapid speech	☐ eating disorder	☐ unexplained memory lapse
☐ panic attacks	☐ body image problems	☐ self harm
☐ phobias	☐ obsessive thoughts	☐ homicidal thoughts
☐ wild mood swings	☐ repetitive behaviors	☐ suicide attempt
☐ extreme anxiety	☐ hallucinations	☐ sleep disturbances

Have you had thoughts of suicide or self harm recently? ☐ frequently ☐ sometimes ☐ rarely ☐ never

Please describe any self-harm you have engaged in_____

Have you ever been hospitalized for psychiatric reasons, including addiction treatment? Where/When?

_____

Have you struggled with shoplifting? Yes No When? _____

Please list medical hospitalizations, operations, and/or major injuries and when they occurred?

_____

Have you ever experienced trauma to your head? How, when? _____

_____

Have you experienced physical, sexual, or emotional abuse? When? Please briefly describe:

_____

_____

Has anyone in your family experienced the following? If yes, please list who (father, sister, grandmother)

Depression	Trauma History	Alcohol/Substance Abuse
Anxiety/Panic Attacks	Bipolar disorder	Learning Disabilities
Schizophrenia	Eating Disorder	Domestic Violence
Jail/Prison	Psychiatric Hospitalization	Suicide

What do you consider to be your strengths? _____

_____

Do you have any significant medical concerns or current conditions? Who is your medical care provider?

_____

_____

Allergies? Yes No Specify: _____

Age of first period (menarche)? _____ Date of last menstrual period? _____

Have you ever experienced amenorrhea (loss of menstrual cycle)? Yes No

How old were you and for how long? _____

Have you experienced irregular menses? Yes No Please explain: _____

What PMS symptoms do you experience and how do you cope with them? _____

_____

Do you have premenopausal symptoms? Please describe: _____

_____

If you have experienced menopause, please describe the process_____

_____

Age of first intercourse: _____ History of abortion? _____

Sexual orientation: _____ Current interest level in sex? _____

Concerns or difficulties in sexual functioning or sexuality? _____

_____

_____

Is there anything else that you would like me to know about you? Any concerns or requests you have for your therapy? _____

_____

What are your life dreams? What gives you joy?_____

_____

_____

EATING HISTORY – This section is applicable for clients seeking treatment for eating and body concerns.

When and how did your eating and body image concerns begin? _____

_____

Please describe your eating, weight, dieting, and body image as a

Young child _____

Adolescent _____

Young Adult _____

Mature Adult _____

Current Weight _____ Lowest weight _____ Highest weight _____

Desired weight_____ Medically appropriate weight range _____

Current Height: _____

Please describe your current eating behavior, thoughts, and rituals , *including frequency of*:

Anorexia _____

Bulimia _____

Binge Eating _____

Other _____

Please describe your current body image _____

_____

What is your relationship to exercise? _____

Have you used: Laxatives Yes No Diet Pills Yes No Diuretics Yes No

Purging Yes No Ipecac Yes No Colonics Yes No Other _____

Do you count calories? If so, how many do you allow yourself to eat per day? _____

Please describe your typical breakfast lunch and dinner _____

_____

What do you imagine your recovered life will be like? Thank you!