Confidential Client History

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Name: _____ Date: _____

DOB: _____ Age: _____ Sex: _____M _____F

Address: _____

Email Address: _____ OK to email you? Yes No

Cell #: _____ OK to leave message? Yes No

Home#: _____ OK to leave message? Yes No

By whom were you referred? _____

Marital Status (check one): ___Single ___Engaged ___Married ___Separated ___Divorced
___Widowed ___Living with someone ___Remarried: How many times?

Partner's name & age (if applicable):

_____

Children (names & ages): _____

_____

Do any of your children have special problems? _____

_____

With whom do you live? _____

What sort of work are you doing now? _____

What kind of jobs have you held in the past? _____

_____

Have you been in therapy before or received any professional assistance for your problems?
___Yes ___No

Was it helpful? Why or why not? _____

_____

Have you ever been hospitalized for psychological/psychiatric problems? ___Yes ___No

If yes, when and why? _____

Are you under the care of a psychiatrist at this time? ___Yes ___No

Name of psychiatrist:_____

Have you ever attempted suicide? ___Yes ___No If yes, when and how? _____

_____

Do any of your family members suffer from an "emotional" or "Mental disorder"? ___Yes ___No

Please explain: _____

Has any relative attempted or committed suicide? ___Yes ___No

Family History:

Father: Name _____Age _____

Occupation: _____ Health: _____

If deceased, age at time of death: _____ How old were you at that time? _____

Cause of death: _____

Mother: Name _____Age _____

Occupation: _____ Health: _____

If deceased, age at time of death: _____ How old were you at that time? _____

Cause of death: _____

Siblings: Age(s) of brother(s): _____ Age(s) of sister(s): _____

Any significant details about siblings: _____

_____

_____

If you were not brought up by your parents, who raised you and between what years?

_____

Give a description of your father's (or father substitute's) personality and his attitude toward you:

(past & present) _____

_____

_____

_____

_____

Give a description of your mother's (or mother substitute's) personality and her attitude toward you:

(past & present) _____

_____

_____

_____

_____

In what ways were you disciplined or punished by your parents?

_____

_____

_____

Describe the home atmosphere in which you grew up: (include compatibility of your parents)

_____

_____

_____

_____

Were you able to confide in your parents? ___Yes ___No

Basically, did you feel loved and respected by your parents? ___Yes ___No

If you have a stepparent, give your age when your parent remarried: _____

Did you experience physical, sexual, verbal, or emotional abuse? ___Yes ___No

By whom and at what age? _____

Highest grade completed in school: _____

Check any of the following that applied to you during your childhood:

___Happy childhood ___Unhappy childhood ___Academic problems ___Behavioral problems

___Emotional problems ___Self harm (ie. cutting) ___Social problems ___Medical problems

___Not enough friends ___Bullied or teased ___Used alcohol ___Used drugs ___Legal trouble

___Death in family ___Financial problems ___Sexually abused ___Ignored ___Severely punished

___Strong religious convictions ___Eating disorder ___Physical fight(s) ___Truancy

___Other (explain) _____

Reason for seeking therapy:

State in your own words the nature of your main problem: _____

_____

_____

_____

_____

On the scale below, please estimate the severity of your problem(s):

___Mildly upsetting ___Moderately upsetting ___Very severe ___Extremely severe ___Incapacitating

When did your problems begin? _____

_____

What seems to worsen your problems? _____

_____

What have you tried that has been helpful? _____

_____

How satisfied are you with your life as a whole these days?

Not at all satisfied 1 2 3 4 5 6 7 Very satisfied

Medical Information:

Primary Care Physician: _____ Last exam: _____

Have you ever been diagnosed with a serious illness? Please describe:

_____

Please list any medications and supplements you are taking:

_____

_____

Do you currently have any medical conditions? If so, please describe:_____

_____

_____

Have you ever been in a 12-Step program? If so, please describe:

_____

_

Do you drink alcohol? ____ Yes ____No

If so, on average, how much in a week and what type do you consume?

_____

Have you ever used illegal drugs or misused prescription drugs? If so, please describe:

_____

_____

Do you have chronic pain? _____

_____

How do you manage your pain? _____

_____

Please circle any of the problems that you are experiencing:

Anxiety	Difficulty Relaxing	Depression	Work too much
Panic Attacks	Flashbacks	Loneliness	Aggressive behavior
Trauma	Poor impulse control	Nightmares	Procrastination
Fears/Phobias	Outbursts of temper	Confusion	Crying
Obsessive thoughts	Low self-esteem	Restlessness	Binge eating
Compulsive behaviors	Self-harm/Cutting	Fatigue	Spend too much $
Appetite changes	Sexual problems	Excessive alcohol use	Can't keep a job
Sleep problems	Marital/Family issues	Problem drug use	Take too many risks

Headaches	Relationship problems	Difficulty trusting	Can't concentrate
Thoughts of suicide	Feelings of hopelessness	Feelings of guilt	Nervousness
Indecisiveness	Less interest in pleasurable activities		Racing thoughts

List your five main fears:

1. _____
2. _____
3. _____
4. _____
5. _____

When are you most likely to lose control of your feelings? _____

_____

_____

_____

Are you bothered by thoughts that occur over and over again? ___Yes ___No

If yes, what are these thoughts? _____

_____

Do you have thoughts or worries that cause you to be in a bad mood? _____

_____

Describe situations that make you feel calm or relaxed: _____

_____

Describe any relationship that gives you joy: _____

_____

Describe any relationship that gives you grief: _____

_____

One of the ways people hurt you is: _____

_____

Are you currently troubled by any past rejections or loss of a love relationship? ___Yes ___No

If yes, please explain: _____

_____

_____

How would your friends and family describe you?

_____

_____

What do you consider to be some of your strengths, special talents, or skills?

_____

_____

Do you have individuals or groups or communities which support and nurture you?

_____

_____

Name the 8 most negative or upsetting experiences of your life:

1. _____

2. _____

3. _____

4. _____

5._____

6. _____

7. _____

8. _____

Expectations regarding therapy:

In a few words, what would you like to accomplish in therapy? _____

_____

_____

How long do you think therapy should last? _____

_____

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

_____

Do you have any particular concerns or fears with regard to therapy?

_____

_____

_____

Is there any additional information you would like to share with me?

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to thoughtfully complete this questionnaire!

It will be a tremendous help in your treatment.