

Name: _____ Today's Date: 10/26/22

DOB _____ Age _____ Is client under 18 years of age? Yes No Name of Person filling out this form and reason: _____

Address: _____ City: _____ ST: _____ Zip: _____

Mailing Address (if different): _____

Phone: (C) _____ (H) _____ (W) _____

Email: _____

May we leave a voice/text message? Yes No If yes, by cell home work email

May we send you an appointment reminder? Yes No If yes, by text v-mail email

Employer: _____ Occupation: _____

Are you a student? Yes No If yes, name of school: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ May we send them a thank you? Yes No

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling: _____

When did these problems or issues develop? _____

What are you hoping to achieve through counseling? _____

Client Problem Assessment

Presenting Problem – Precipitating Stressors: “In recent months, I have been concerned about...”

Please check all that apply, past or present

Marriage Spouse/Partner Parent/Child Family of Origin Extended Family

Abuse (physical sexual psychological neglect) Guilt Shame

Cultural/Ethnic/Race Health Job Financial

Other: _____

Symptoms Please check all that apply:

- Decreased Concentration
- Disturbance in Sleep Patterns
- Decreased Interest in Activities
- Unexplained Physical Problems
- Decreased Motivation
- Increased Stress
- Numbness or Tingling
- Body Tension
- Decreased Energy
- Loss of Control
- Chest Pains / Discomfort
- Thoughts of Death/Suicide

Other: _____

Major Life Events Please check all that apply:

- Death of a family member/friend
- Personal injury/illness
- Career change
- Divorce
- Marriage
- Legal problems
- Separation
- Job loss
- Relocation
- Imprisonment
- Pregnancy/complications
- Holidays
- Financial

Other: _____

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes No

Is there a history of suicide/homicide in your nuclear and/or extended family? Yes No

Are you presently suicidal/homicidal? Yes No

If yes, explain (how, when, where, what method, why): _____

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes No

Have you ever subjected another person to physical harm? Yes No

If yes, explain (how, when, where, what method, why): _____

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses.

Strengths

Weaknesses

Living Arrangements

Current Address: _____ How Long: _____

With whom do you live? _____

Current relationship with others where you live: _____

Relationship History

Sexual Orientation: _____

Are you married? Yes No If not married, are you in a relationship? Yes No

Name and age of spouse/partner: _____

Date of marriage/cohabitation: _____

Previous marriage/relationship: Yes No If yes, name of spouse/partner: _____

If yes, date of divorce/end of partnership: _____

Where children involved in the previous marriage/partnership: Yes No

What is your perception of the status of your *current* relationship? (include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.) _____

Name, ages, and relational history of children from marriages/partnerships.

<u>Name</u>	<u>Age</u>	<u>Comments</u>	<u>Bio, Step, Adopted</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental History

List the members of your family of origin/adoption and your compatibility with each one now.

<u>Family Member</u>	<u>Comments</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order: # _____ of _____ children. Who primarily raised you? _____

How would you describe your childhood? Uneventful Boring Traumatic Painful
 Unhappy Ignored Neglected Withdrawn Other _____

What was life like for you as a child? (Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.) _____

Did you experience any traumatic events as a child or adult? (Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)

<u>Date</u>	<u>Age</u>	<u>Event</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Who do you depend on for support? (Check all that apply)

- Parents Siblings Spouse Children Employer Church Pastor
- Therapist Extended Family Neighbor(s) Close Friend(s) Co-Worker(s)
- Doctor(s) Support Group(s) Community Services Other: _____

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes No

If yes, explain who and why (complete release of information consent form if needed): _____

Legal History (Please explain all that apply, past and present)

Charges as a minor: _____

Current Charges: _____

Arrests: _____

Convictions: _____

Parole/Probations: _____

Bankruptcies: _____

Divorce/Separation: _____

Foreclosures: _____

Civil Suits: _____

Financial Situation

Briefly describe your financial situation: _____

Work History

Describe your current job/career: _____

What do you like or dislike about your job and/or career?

Like

Dislike

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

Have you ever been fired from a job? Yes No If so, please explain: _____

Educational History

Describe what school was like for you: _____

Highest level of education: _____ What kind of grades did you make? _____

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background: _____

Do you have a religious/spiritual background? Yes No Preference _____

Do you attend religious/spiritual services? Yes No If so, where and how often? _____

Medical History

How would you describe your current health? _____

Are you currently on medications? Yes No If yes, please provide information.

<u>Name of Medication</u>	<u>Dosage/Frequency</u>	<u>Prescribing Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has it been more than a year since your last physical exam, including blood work? Yes No

Have you had or were you involved with an abortion? Yes No Miscarriage? Yes No

List any previous health issues including surgeries, procedures, and medical hospitalizations:

<u>Problem</u>	<u>Date</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Counseling History *(Please list all previous psychotherapy experiences.)*

Are you or have you ever participated in counseling or psychotherapy treatment? Yes No

If yes, please provide as much information as possible.

<u>Date(s)</u>	<u>Provider</u>	<u>Reason for Treatment</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric History *(Please list all previous inpatient / outpatient experiences.)*

Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes No

Have you ever been hospitalized for mental health related issues? Yes No

Have you ever been hospitalized for mental health issues related to substance abuse? Yes No

If you answered yes to any of the above, please provide as much information as possible.

<u>Date(s)</u>	<u>Provider</u>	<u>Reason for Treatment</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep: _____

Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes No If yes, please explain.

Has anyone in your family had problems with alcohol or drugs that was not treated? Yes No If yes, please explain.

<u>Family member</u>	<u>Problem/Disorder</u>	<u>Treatment Results (if any)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Use / Abuse History

Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Age of 1st use</u>	<u>Age regular use started</u>	<u>Age last used</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced an increase in the use of alcohol and/or other substances? Yes No

Do you see your usage as a problem? Yes No If yes, when did it become problematic?

Please describe any previous experience with substances or alcohol _____

Please describe any family history of substance and/or alcohol use _____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes No If so, please describe _____

Nutrition

Have your eating habits changed recently? Yes No If so, please describe _____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes No

Do you often eat out of depression, boredom, and/or anger? Yes No If yes, please describe _____

Do you use laxatives, water pills (diuretics), or diet medications? Yes No If so, how often and for what purpose do you use them? _____

Additional Information

Is there any other information that can be helpful for us to know about you? _____

Client Signature

Date

For Office Use Only – Clinician Notes

Adverse Childhood Experiences Questionnaire
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **OFTEN** . . .
Swear at you, insult you, put you down, or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **OFTEN** . . .
Push, grab, slap, pull your hair, or throw something at you?
OR
EVER hit you so hard that you had bruises, marks, or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **EVER** . . .
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you **OFTEN** feel that . . .
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **OFTEN** feel that . . .
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
OR
Your parents were too intoxicated to care for you or take you to a doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **EVER** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother, stepmother, grandmother, or other significant female caretaker . . .
OFTEN pushed, grabbed, slapped, had her hair pulled, or had something thrown at her?
OR
SOMETIMES or **OFTEN** kicked, bitten, hit with a fist or hit with something hard?
OR
EVER repeatedly struck over several minutes or threatened with a gun or a knife?
Yes No If yes enter 1 _____
8. Did you **EVER** live with anyone who was a problem drinker, an alcoholic, or used drugs?
Yes No If yes enter 1 _____
9. Has a household member **EVER** been depressed, mentally ill, or attempted suicide?
Yes No If yes enter 1 _____
10. Has a household member **EVER** been arrested, gone to jail, or been in prison?
Yes No If yes enter 1 _____

Now add up your "YES" answers: _____ This is your ACE score.