ALLIANCE COUNSELING
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PSYCHOSOCIAL INFORMATION

CLIENT PERSONAL DATA:

1. Date of Birth: ________________ Age: ______ Place of Birth: __________________
2. Your mother's condition during pregnancy & delivery *(as far as you know)*:
____
____
3. Check any of the following that apply during your childhood:

☐ Night Terrors	☐ Happy Childhood	☐ Lonely
☐ Thumb sucking	☐ Sleep walking	☐ Violent
☐ Fears	☐ Stammering/Stuttering	☐ Nurturing
☐ Bedwetting	☐ Unhappy Childhood	☐ Write in
☐ Nail Biting	☐ Chaotic	☐ Write in

4. Were there any significant childhood illnesses or hospitalizations? ☐ No ☐ Yes, *Explain.*
____
____
5. Have there been any accidents/events/circumstances that have significantly influenced your life up to his point? ☐ No ☐ Yes, *Explain.*
____
____
6. Check any of the following that you would apply to yourself:

☐ Headaches	☐ Dizziness	☐ Fainting spells
☐ Palpitations	☐ Stomach trouble	☐ Anxiety / Panic Attacks
☐ Bowel disturbances	☐ Fatigue	☐ No appetite
☐ Anger outbursts	☐ Take sedatives	☐ Insomnia
☐ Nightmares	☐ Feel panicky	☐ Alcoholism
☐ Depressed	☐ Suicidal ideas	☐ Take drugs
☐ Unable to relax	☐ Sexual problems	☐ Allergies
☐ Can't make friends	☐ Can't make decisions	☐ Shy with people
☐ Over ambitious	☐ Can't keep a job	☐ Memory problems
☐ Financial problems	☐ Unable to have a good time	☐ Concentration difficulties

7. What are your current interests, hobbies, and activities?
____
____

EDUCATION DATA:

8. Highest level completed: __________ GED: ______ Degree: ____________________

   Grade school(s) attended: ____

   Middle school(s) attended: ____

   High school(s) attended: ____

   Vocational program attended: ____

   College attended: ____

   Graduate School attended: ____

9. Favorite Subjects: ____________________________________Typical Grades: ______

   Least Favorite: ____________________________________Typical Grades: ______

10. Did you receive any support services in school? ☐ No ☐ Yes (Check all that apply)

    ☐ Special Education ☐ Had an I.E.P. ☐ Speech & Language ☐ Motor (Occupational / Physical Therapy)
    ☐ 504 Plan ☐ Repeated a grade: _____ ☐ Suspended ☐ Becca Bill

11. Were you ever bullied or severely teased? ☐ No ☐ Yes, *Explain*

    ____

    ____

12. Do you make friends easily? ☐ No ☐ Yes, *Explain*

    ____

    Do you have a best friend? ☐ No ☐ Yes, *When did you meet?*

    ____

13. Please describe your educational experience and/or any significant event(s) that may pertain to your coming to counseling:

    ____

    ____

14. Check any of the following that you participated while in school:

    ☐ Student Government ☐ Dance/Cheerleading ☐ Clubs
    ☐ Sports ☐ DECA / FBLA ☐ ROTC
    ☐ Theater/Band/Orchestra ☐ FFA ☐ Debate

    Other Activities:

    ____

15. Did you earn/receive any awards/recognition during your schooling? ☐ No ☐ Yes, *Explain*

    ____

OCCUPATIONAL DATA:

16. What sort of work are you doing now? Job title: ______________________________
    Name of Employer:

    ____

17. List previous jobs held:

    ____

18. Does your present work satisfy you? ☐ No ☐ Yes, *(If not, Explain)*

____

19. What are your goals/ambitions regarding work?

____

LEGAL DATA:

20. Are you involved in any legal affairs currently? ☐ No ☐ Yes, *(If yes, Explain)*

____

21. Have you ever been detained/incarcerated? ☐ No ☐ Yes, *(If yes, Explain)*

____

22. Have you ever been required to attend or been involved in:

☐	Anger Management Classes	☐	Parenting Classes
☐	Chemical Dependency Treatment	☐	Impact of Divorce on Children Class
☐	DUI	☐	Domestic Violence
☐	CPS Referral	☐	Other

CLIENT FAMILY DATA:

23. **Father** - ☐ Living ☐ Deceased, If deceased, your age at time of his death: __________

Name: ______________________ Cause of death: ______________________

If alive, Father's present age: _____ Occupation: ______________________

Father's current health: ______________________

24. **Mother** - ☐ Living ☐ Deceased, If deceased, your age at time of her death: __________

Name: ______________________ Cause of death: ______________________

If alive, Mother's present age: _____ Occupation: ______________________

Mother's current health: ______________________

25. **Siblings** *(bio/step/or half)*

Number of Brothers: _______ Brothers' Names & Ages: ______________________

Number of Sisters: _______ Sisters' Names & Ages: ______________________

26. Please briefly describe your present relationship with your brothers & sisters:

____

27. **Your Children**

Number of Sons: ______ Names & Ages: ______________________

Number of Daughters: _______ Names & Ages: ______________________

28. Please briefly describe your present relationship with your sons & daughters:

____

29. How would you describe your father?

____

____

30. How would you describe your mother?

____

____

31. In what ways were you disciplined/punished by your parents as a child?

____

____

32. Check any of the following that you apply to you and your family:

- ☐ Could confide in parents
- ☐ Parents understood you
- ☐ Parents respected you
- ☐ Family was normal
- ☐ There were secretes
- ☐ Had no freedom
- ☐ Family was abnormal
- ☐ Could do what I wanted
- ☐ Lots of rules

Other Impressions of your home of origin:

____

33. If you were not raised by your parents, who did raise you and between what years?

____

34. Who are the most important people in your life?

____

DRUG & ALCOHOL ABUSE DATA:

35. Have you used any of these substances in the past 12 months?
(Check all that apply)

Substance	Date of Last Use	Substance	Date of Last Use
Alcohol		LSD	
Marijuana		Mushrooms	
Methamphetamine/Stimulants		Pain Killers	
Heroin/Opiates		Tobacco	
Inhalants		Caffeine	
Cocaine		Other:	

Have you ever had treatment for substance use? ☐ No ☐ Yes

Dates of chemical dependency treatment ________________ ☐ Outpatient ☐ Inpatient

Do you attend 12-Step or CD support groups? ☐ No ☐ Yes

36. Do you have any family history of drug and/or alcohol abuse? ☐ No ☐ Yes, *Explain*

____

____

37. Do you have any family history of mental illness? ☐ No ☐ Yes, *Explain*
Any diagnoses:

____

____

38. Do you have any medical problems currently? *(Check all that apply)*

☐ Difficulty Sleeping
☐ Appetite Problems
☐ Weight Gain or Loss
☐ Memory Problems
☐ Trouble Concentrating
☐ Headaches
☐ Heart
☐ Lungs
☐ Diabetes
☐ Liver Problems
☐ Seizures
☐ Skin
☐ Stomach
☐ Joints
☐ Back Problems
☐ Allergies
☐ Bed Wetting
☐ Other (Describe) ____________

MEDICATIONS: List all medications you are currently taking

Name of Medication	How Much?	How Often?	Date Last Taken	Reason for Taking?	Who Prescribed?

MEDICAL INFORMATION:

Do you have a medical doctor? ☐ *No* ☐ *Yes, If yes, name of doctor* ____________________

Phone #: ________________ Date of last physical examination: ________________

Do you have a specific diagnosed medical condition? ☐ No ☐ Yes, If yes, please explain:

____

Does you wear corrective lenses? ☐ No ☐ Yes Do you have any hearing difficulties? ☐ No ☐ Yes

Have you had a serious injury or illness requiring hospitalization? ☐ No ☐ Yes, If yes, please explain:

____

MARITAL / LONG-TERM RELATIONSHIP DATA:

39. If you are married or are in a long-term relationship, how long have you been together?

____

40. Your spouse or partner's name is:______________________ Age: ______

Occupation: ______________________ How Long: ______

41. What do you consider are the strengths of your relationship?

____

42. What causes the most conflict?

____

43. Do you get along with your spouse/partner's parents? ☐ No ☐ Yes, *Explain*

____

44. How many children do you have? *(List gender and ages)*

____

45. Please comment on any previous marriage or long-term relationship?

____

____

RELIGION DATA:

46. What is the role of religion and/or spirituality in your life?

a) In childhood: ______________________________

b) As an adult: ______________________________

SEXUAL DATA:

47. Are there any experiences/events regarding your sexual life/health that need to be addressed at this time? ☐ No ☐ Yes, *Explain*

____

FINANICAL DATA:

48. Are there any experiences/troubles regarding your financial affairs that need to be addressed at this time? ☐ No ☐ Yes, *Explain*

____

49. Checklist Regarding Behavior & Mood:

Check all that apply to you	**BEHAVIOR**	
Inattentive	Annoys Others	Not learning from mistakes
Hyperactive	Argumentative	Serious Rule Violations
Impulsive	Negative/talks abusively to others	Criminal Activity
Destruction of Property	Tantrums/Rage	Blames Others
Episodes of Violence/Aggression	Social Withdrawal	Self-Harm
Appetite Issues	Difficulty Sleeping	Poor Concentration
Fidgets	Reckless Behavior	Physical/Sexual Abuse
Poor Self Care	Nightmares	Suicidal Ideation
Relationship Problems	Chem. Dependency Issues	Runs Away / Truancy
Bizarre Behaviors	Inappropriate sexual advances or behaviors	Physically or sexually assaultive- actual threatened
Others (describe)________________		

Check all that apply to you	**MOOD**	
Excessive Worry	Feelings of Worthlessness	Separation Issues
Bodily Complaints	Depression	Social isolation/withdrawal
Mood Lability	Loss of interest or pleasure	Anxious
Panic	Low self-esteem	Cries Easily
Other (describe)________________		Irritability

50. What are your desired outcomes for therapy?

____

____

51. What is there about your present *behavior* that you would like to change?

____

____

52. One of the ways I could help myself but don't is?

____

53. One question I wish you would have asked about me but didn't would be:

____

Other comments or concerns:

Thank you for taking time to complete this lengthy questionnaire.

GAD-7 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** (Circle to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day	Row Total
1. Feeling nervous, anxious, on edge	0	1	2	3	
2. Not being able to stop or to control worrying	0	1	2	3	
3. Worrying too much about different things	0	1	2	3	
4. Trouble relaxing	0	1	2	3	
5. Being so restless that it is hard to sit still	0	1	2	3	
6. Becoming easily annoyed or irritable	0	1	2	3	
7. Feeling afraid as if something awful might happen	0	1	2	3	
					Total Score

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** (Circle to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day	Row Total
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed, or hopeless	0	1	2	3	
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. Poor appetite or overeating	0	1	2	3	
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3	
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
					Total Score