Blue Ash Counseling Center

9475 Kenwood Rd, Suite 13, Blue Ash, OH 45242

Phone: (513) www.blueashcounselingcenter.com

**Adult History**

**Name: Date:**

**CURRENT SITUATION (presenting problem(s), precipitant(s), recent major stresses or life changes)**

**HEALTH AND WELLNESS HISTORY**

Primary Care Physician: Date of Last Visit to Physician:

Date of Last Physical: Insurance:

Please describe what you do to relax or take care of yourself:

Do you exercise? Yes No If yes, how many times per week? Intensity: High Medium Low

Height Weight Do you have any drug/food allergies? Yes No If yes, please specify.

Do you have any physical health problem(s)? Yes No If yes, what condition(s)?

How would you describe the nutritional value and balance of your diet: Excellent Good Fair Poor  
Have you had significant appetite change over the past month? Yes No

Comments:

Have you had any weight change in the past 6 months? Yes No If yes, amount +/-

Comments:

Have you experienced any sleep disturbance in the past month? Yes No  
Comments:

Are you **currently** on any prescriptions, "over the counter" vitamins, herbs, supplements for anxiety, depression, mental  
health conditions or other medical conditions? Yes No If yes, list all medications:  
Medication/Purpose:

In the **past,** have you taken any medication for anxiety, depression or mental health condition? Yes No If yes, list all  
medications:

Are you having any problems or concerns with your sexual functioning? Yes No

Comments:

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**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BEHAVIORAL HEALTH**

Have you had prior mental health services, counseling, or alcohol/drug treatment? If Yes, please list names and dates below.

Out Patient Inpatient

Therapist or Program Name Date Hospital

**Yes No**

Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
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|  |  |  |  |  |

Regarding past or current treatment, what have you found most helpful? What has not been particularly helpful or  
effective?

Have you ever experienced:  
Physical abuse Yes No  
Sexual abuse Yes No  
Rape/sexual assault Yes No  
If Yes to any of the above explain:

|  |
| --- |
|  |
|  |
|  |

Domestic violence Emotional abuse Other significant trauma

**Yes No Yes No**

**Yes No**

Are you now or have you in the past experienced any suicidal feelings/behavior? Yes No If yes, please describe.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of violent/aggressive behavior?Yes No If yes, please describe below

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Are you having difficulty with any activities of daily living?

If yes, indicate with which activities the client requires assistance from another person:

Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| * Grooming/hygiene | * Homemaking | * Mobility | * Leisure Skills |
| * Bathing | * Shopping | * Transportation | * Time Management |
| * Dressing | * Banking | * Communication | * Stress Management |
| * Cooking | * Budgeting | * Child Care | * Other ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Describe any recent difficulties:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Adult History

**Name:**

**CULTURAL/ETHNIC/SPIRITUAL**

Cultural/ethnic/racial issues that need consideration? Yes No

If Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sexual Orientation issues that need consideration?  Yes No

If Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Religious/spiritual issues that need consideration? Yes No

If Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY/CURRENT LIVING SITUATION**

List household members:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to client |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List children not residing in the home:

|  |  |  |
| --- | --- | --- |
| Name | Age | Living Arrangements |
|  |  |  |
|  |  |  |
|  |  |  |

Describe any concerns about family members:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there any history of emotional or mental problems in the family? Yes No

If Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Name:**

**MILITARY SERVICE**  Yes No

If Yes, Type of Discharge:

Were you involved in combat duty? Yes No  
If Yes, please describe combat situation:

**EMPLOYMENT**

Full-time Part-time Unemployed Since Student

Homemaker Volunteer Retired Since Disabled Since\_\_\_\_\_\_\_\_\_\_\_

How long at current job? How long at last job?

Are you having any problems at your workplace? Yes No  
If Yes, describe:

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**FINANCIAL**

Are you having financial problems? Yes No  
If Yes, please describe:

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**LEGAL**

Have you ever had involvement with the legal system? Yes No

If Yes, explain when, what involvement, and the outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any current pending legal charges? Yes No

If Yes, explain:

Are you on probation or parole? Yes No  
If Yes, list PO's name and contact information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been incarcerated (in jail)? Yes No  
If Yes, explain:

Adult History 4

**Name:**

**ALCOHOL AND DRUG USEAGE**

Do you smoke cigarettes or use tobacco in any other form? Yes No

If yes, describe (how often, how much):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No

If yes, describe (how often, how much):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs? Yes No

If yes, what were your concerns?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has anyone else expressed concerns about your use of alcohol, prescription medications or other drugs? Yes No

If yes, who was concerned and what were their concerns?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever made a decision to cut down or quit using alcohol and/or other drugs? Yes No

If yes, what made you decide to cut down or quit and what was the outcome of your efforts to cut down or quit?

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Have you ever experienced any of the following in connection with your use of alcohol, prescription medications, or other drugs?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes No | Financial Problems | Yes No | Relationship Problems |
| Yes No | Work Problems | Yes No | Increased Tolerance |
| Yes No | Physical Problems | Yes No | Emotional Problems |
| Yes No | Blackouts | Yes No | Withdrawal Symptoms |
| Yes No | Cravings | Yes No | Legal |

Has anyone in your family ever had problems with alcohol or other drug use? Yes No

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Client’s signature |  | Date |  |
| Reviewed/completed by Clinician |  | Date |  |
| Reviewed/updated by clinician |  | Date |  |