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If currently in a relationship:

Briefly describe the nature of the relationship \_\_\_\_\_

Partner's Age: \_\_\_\_ Has your partner previously been married? \_\_\_\_ How many Times? \_\_\_\_  
 How long since partner's last marriage? \_\_\_\_\_ Does your partner have children from a  
 previous relationship? \_\_\_\_\_ Names / Ages of children: \_\_\_\_\_

Education, degrees? \_\_\_\_\_ Occupation? \_\_\_\_\_  
 Is partner currently employed? \_\_\_\_\_ How long? \_\_\_\_\_

***With Whom are you currently living?***

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol / Drugs Mental Illness or Other Problems

Do you have any children who **do not** live with you? \_\_\_\_\_  
 Names / Ages: \_\_\_\_\_

Do you have any children who **are not** in your custody? \_\_\_\_\_  
 Names / Ages: \_\_\_\_\_

Do you have any children with whom you share custody with another parent other than someone  
 you currently live with? \_\_\_\_\_  
 Name of Parent: \_\_\_\_\_ Phone number: \_\_\_\_\_

***Extended Family and Friends***

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol / Drugs Mental Illness or Other Problems

In a few words, how would you describe your mother? \_\_\_\_\_  
 \_\_\_\_\_ your father? \_\_\_\_\_  
 \_\_\_\_\_

How was it to grow up in your family? \_\_\_\_\_

\_\_\_\_\_

**D. Educational / Occupational / Military**

Highest grade / degree completed: \_\_\_\_\_

Current student? \_\_\_\_\_ Where? \_\_\_\_\_ What are you studying? \_\_\_\_\_

Current Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

If not employed, how long has it been since you worked? \_\_\_\_\_

What kind of job did you have? \_\_\_\_\_

What caused you to stop working? \_\_\_\_\_

What other types of work have you done in the past? \_\_\_\_\_

Have you ever been or are you now in the military? \_\_\_\_\_

Which Branch? \_\_\_\_\_

What was your specialty? \_\_\_\_\_

What was your rank at discharge? \_\_\_\_\_ Honorable Discharge? \_\_\_\_\_

**E. Health / Medical**

From whom or where do you receive medical care? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

When was your last medical exam? \_\_\_\_\_

Current health concerns: \_\_\_\_\_

Are you currently receiving treatment for these concerns? \_\_\_\_\_

Past health concerns and accidents: \_\_\_\_\_

List current medications/vitamins/supplements: \_\_\_\_\_

\_\_\_\_\_

**Women only:**

How many pregnancies have you had? \_\_\_\_\_ Are you pregnant now? \_\_\_\_\_

Any miscarriages? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

**Men and Women:**

Are you sexually active? \_\_\_\_\_

Do you use birth control? \_\_\_\_\_

Do you practice safe sex? \_\_\_\_\_

Have you ever been concerned about your eating habits? \_\_\_\_\_ If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been concerned about your sleep habits? \_\_\_\_\_ If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

Do you exercise? \_\_\_\_\_ If yes, how often? \_\_\_\_\_ What do you do?

\_\_\_\_\_

**F. Spiritual/Religious Beliefs/Practices: (please answer any or all of the following)**

Is Religion or spirituality important to you? \_\_\_\_\_

Do you consider yourself a spiritual person? \_\_\_\_\_

Are you affiliated with any particular religion or place of worship? \_\_\_\_\_

If yes, what is it? \_\_\_\_\_

What gets you through difficult periods in your life? \_\_\_\_\_

\_\_\_\_\_

What brings you hope and joy? \_\_\_\_\_

\_\_\_\_\_

### **G. Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? \_\_\_\_\_ If yes, please indicate:

<b>When?</b>	<b>From Whom?</b>	<b>For What?</b>	<b>With What Results?</b>

Are you thinking about suicide now? \_\_\_\_\_ If yes, why? \_\_\_\_\_

\_\_\_\_\_

Have you ever thought about suicide in the past? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_\_ If you answered yes to one or both of these, please indicate:

<b>When?</b>	<b>Why?</b>	<b>What did you do?</b>	<b>What happened?</b>

Do you now or have you ever engaged in self-harm (e.g. cutting, burning, or hurting yourself in any way) or other potentially damaging or impulsive behaviors (e.g. unsafe sex practices, gambling, impulsive spending)? \_\_\_\_\_ If yes, please describe. Include when you started, frequency, what you did, the last time you engaged in the behavior(s) and anything else you think is important for me to know. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you now, or have you ever been, the victim or any kind of abuse (emotional, physical, sexual)? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you now or have you ever taken medications for psychiatric or emotional problems? \_\_\_\_\_

If yes, please indicate:

<b>When</b>	<b>Prescriber</b>	<b>Medication</b>	<b>For What?</b>	<b>Results</b>


**H. Chemical Use**

Do you believe you have a drug or alcohol problem? Currently? \_\_\_\_\_ Past? \_\_\_\_\_

List all tobacco, non-prescribed drugs, and alcohol, that you are currently using or have used in the past:

Type	First Used	Last Used	Amount/Frequency

**I. Legal**

Please list and describe any arrests or legal issues or problems (include custody): \_\_\_\_\_

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**J. Presenting Concern:** Please describe the main difficulty or reason you are coming for counseling. Why now?:

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**Circle any problem that pertains to you at this time:**

- |              |               |                    |                |
|--------------|---------------|--------------------|----------------|
| Nervous      | Relaxation    | Making decisions   | Stress         |
| Shyness      | Legal matters | Self-control       | Memory         |
| Separation   | Energy        | Inferiority        | Appetite       |
| Drug use     | Loneliness    | Bowel problems     | Marriage       |
| Anger        | Education     | Sexual problems    | Work           |
| Sleep        | Undereating   | Alcohol use        | Overeating     |
| Friends      | Concentration | Nightmares         | Temper         |
| Fatigue      | Ambition      | Stomach problems   | Divorce        |
| My thoughts  | Parenting     | Health problems    | Age            |
| Finances     | My appearance | Suicidal thoughts  | Future         |
| Sexual abuse | Children      | Career choices     | Weight         |
| Unhappiness  | Depression    | Headaches          | Fears          |
| Phobias      | Self-esteem   | Sexual Orientation | Physical abuse |
| Anxiety      |               |                    |                |

**Circle everything that has happened to you in the past 3 years:**

- |                                       |                                     |                           |
|---------------------------------------|-------------------------------------|---------------------------|
| Death of a spouse/partner             | Marriage Problems                   | Changes in marital status |
| Death of another family member        | Family problems (children, in-laws) | Loss of job               |
| Major illness or injury—yourself      | Financial problems                  | Move                      |
| Major illness or injury—family member | Legal problems                      | Other: _____              |

Please describe your strengths: \_\_\_\_\_

Please describe your limitations: \_\_\_\_\_

Who/What are your supports: \_\_\_\_\_

Please rate your level of motivation for change (0 to 10 with 10 the highest) \_\_\_\_\_

Please describe your goals for counseling: \_\_\_\_\_

Please list any additional information that you believe may be helpful or that you want me to know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_