Karen Marullo, MA, LPC

Client History and Information

Basic Information:

Date: _____
Patient Name: _____
Social Security Number: _____
Date of Birth: _____
To which gender do you identify?: [ ] Cis-Gender Female [ ] Transgender Female [ ] Cis-Gender Male [ ] Transgender Male [ ] Nonbinary [ ] Other: _____ [ ] Prefer not to answer
Race/Ethnicity: _____

Home Address:
Home Phone Number: _____ May we leave a message? [ ] Yes [ ] No
Work Phone Number: _____ May we leave a message? [ ] Yes [ ] No
Mobile Phone Number: _____ May we leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:
Name of Guardian: _____
Address of Guardian: _____
Guardian's Home Phone: _____ May we leave a message? [ ] Yes [ ] No
Guardian's Work Phone: _____ May we leave a message? [ ] Yes [ ] No
Guardian's Mobile Phone: _____ May we leave a message? [ ] Yes [ ] No

If you will be using insurance to cover your sessions or a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:
Primary Insurance Company: _____
Secondary Insurance Company if applicable: _____
Referral Source: _____
Who referred you to our office, or how did you learn about our practice? _____

Emergency Contact Information

In case of an emergency, who should we contact?
Name: _____
Relationship: _____
Address: _____
Phone Number: _____

History Information

Who is providing the history information?
[ ] The patient
[ ] The patient's guardian
[ ] Other
Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?
Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tension
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated
[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Distorted body image
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career [ ] Other:

Previous Treatment
Have you received or participated in previous counseling and/or therapy?
[ ] Yes [ ] No
Additional Information:
What did you like/dislike about previous treatment?
What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?
Have you had hospital stays for psychological concerns?

[ ] Yes [ ] No

Additional Information:
Are you currently experiencing thoughts of harming either yourself or someone else?
[ ] Yes [ ] No
Have you in the past experienced thoughts of harming either yourself or someone else?
[ ] Yes [ ] No

Developmental History
Are you aware of any difficulties or complications during the time your mother was pregnant with you?
[ ] Yes [ ] No
If yes, explain:
Did you walk, talk, and read on time?
[ ] Yes [ ] No
Explain:
Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?
Are you satisfied at where you are in your life?
If not, where would you like to be?

Medical History
List any current or important past medications
Medication & Dose Response to Medication:

History of serious childhood illnesses:
Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

Have you experienced any head injuries?
[ ] Yes [ ] No
Important Details:
If yes, did you lose consciousness?
[ ] Yes [ ] No
Have you experienced convulsions or seizures?
[ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No
Explain any allergies you have:
How would you rate your current physical health?
[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ]Very Poor
What was the date of your last physical or routine health "check up?"
Do you have a primary care physician?
[ ] Yes [ ] No
If yes, complete the following:
Name:
Address:
Phone Number:

Family History
Birth Location:
Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other:
Relationship with parent figures: (good, fair, poor, close, distant, etc.)
Mother:

Father:
Step-parent:
Other:
List your siblings and describe your relationship with them?
Name:
Age:
Gender:
Nature of Relationship:

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Any Additional Family Information:

Social History
Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe your religious/spiritual background and affiliation:

Educational History
When attending school were you:
[ ] In regular classes [ ] Home Study [ ] Special classes [ ] Advanced classes
[ ] Ever suspended [ ] Placed in alternative school
What is the highest educational level you have completed?
Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

Occupational History
What is your current employment status?
[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed [ ] Self-employed [ ] Student
[ ] Other
Are you satisfied with your employment?
If not, why?

Marital History
Which best describes your marital status?
[ ] Married, Date: _____
[ ] Never Married
[ ] Widowed, Date:
[ ] Separated, Date:
[ ] Divorced, Date: _____
If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction?
[ ] Poor [ ] Fair [ ] Good [ ] Great
Please list any previous marriages/significant relationships including current:

Name:
Date:
Nature of Relationship:
Do you have children?
[ ] Yes [ ] No
If yes, complete the following:
First Name:
Age:
Gender:
Nature of Relationship:
Are there presently any child custody issues involving you or your family?
[ ] Yes [ ] No
Does your family currently have Child Protective Services Involvement?
[ ] Yes [ ] No
If yes please complete the following:
Case Worker's Name:
Phone:

Substance Abuse History
Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)
[ ] Yes
[ ] No
If you answered yes, please complete the following substance abuse history:
Substances Ever Used Yes/No
Age of First Use:
Frequency of Use (Daily, Weekly, Monthly)
Amount Used:
How did you use it? (smoked, injected, etc.)
Alcohol
Marijuana
Cocaine or Crack
Heroin
Amphetamines
Club Drugs (Ecstasy, Inhalants, etc.)
Pain Medication (Oxycontin, Vicodin, etc.)
Benzodiazepines
Hallucinogens
Other
Complete the following if you have ever received treatment for a substance abuse issue.
Name of Treatment Program:
Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)
Date of Treatment :(Month, Year)
Outcome (Any Clean time?):

Legal History
Do you currently have any pending criminal charges?
[ ] Yes [ ] No
Are you on probation?
[ ] Yes [ ] No
Name of Probation Officer and County

Have you ever been arrested/convicted of a crime?
[ ] Yes [ ] No: If yes, complete:
List any Arrests/Convictions
Date of Arrests/Convictions:
Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)
Additional Information:

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_____ _____

Signature of client or guardian Date