SANTA ROSA COUNSELING CENTER

BIOPSYCHOSOCIAL HISTORY

The following necessary information will help make your first session most productive. If you are court-mandated to receive counseling, please be prepared to provide the order or case plan. Please **PRINT** and fill out this form **COMPLETELY**.

DEMOGRAPHICS Date of Assessment: _____

Last Name | First | Middle | Date of Birth | Age

Home Street Address | City | State | Zip Code | County

Phone Number (Cell) | Home | Email | Parent/Guardian Name *(if assessment for child)*

Gender: ☐ Male ☐ Female Legal Marital Status: ☐ Single ☐ Married Additional Status: ☐ Separated ☐ Divorced ☐ Partnered

HISTORY OF PRESENT PROBLEM

Why are you seeking treatment at this time? *(include symptoms, onset, duration, frequency, etc.)*

What do you hope to gain from counseling?

Check all problematic experiences or events within the past 90 days?

☐ Abuse/Violence
☐ Academic Problems
☐ Addiction/Dependency
☐ Anger Management
☐ Anxiety/Panic
☐ Behavior
☐ Concentration/Focus
☐ Cruelty to Animals
☐ Depression
☐ Developmental Delay
☐ Employment Problems
☐ Extramarital Affair
☐ Family/Parenting
☐ Fire Setting
☐ Grief
☐ Hallucinations
☐ Hospitalization
☐ Hyperactivity/Impulsivity
☐ Intrusive Thoughts
☐ Legal Problems
☐ Mood Swings
☐ Obsessive Thoughts
☐ Paranoia/Delusions
☐ Physical/Medical
☐ Poor Sleep Patterns
☐ PTSD/Trauma
☐ Relationship
☐ Self-injury
☐ Suicidal Thoughts
☐ Suicide Attempts
☐ Thoughts to Harm Others
☐ Weight Gain/Loss

PSYCHIATRIC HISTORY When and where?

Have you ever been in counseling before? ☐ Yes ☐ No _____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No _____

Describe **family history** of mental health problems or suicide (attempts): _____

TRAUMA HISTORY

At your comfort level, indicate nature of traumatic experience or event, when occurred, persons involved:

☐ Prefer to disclose later

MEDICAL CONDITIONS & HISTORY

Who is your primary care physician? _____

Medical or Psychiatric Diagnosis	Medication Prescribed	Dosage	Physician / ARNP

Provider Notes

Santa Rosa Counseling Center
5642 Jones Street, Milton, Florida 32570
Office (850) 626-7779 Fax (850) 626-7171
santarosacounselingcenter.com

SANTA ROSA COUNSELING CENTER

Are you experiencing physical pain that causes mental health issue? ☐ Yes ☐ No

Describe your sleep patterns: _____

SUBSTANCE USE HISTORY

Describe any substance use history, including casual or recreational: *(include alcohol and tobacco usage)*

_____

_____

FAMILY HISTORY

Describe who you were **raised by** and the family relationship:

_____

Describe the relationship with your **siblings**: *(with names and ages)*

_____ ☐ not applicable

Describe the relationship with your **spouse or partner**: *(with name and age)*

_____ ☐ not applicable

Describe the relationship with your **children**: *(with names and ages)*

_____ ☐ not applicable

SOCIAL HISTORY

Who is your support system? _____

Describe activities/relationships you have recently started or stopped:

_____

Describe your leisure/recreational activities:

_____

EDUCATIONAL / OCCUPATIONAL HISTORY

What is your highest level of education? _____ ☐ Current student

Where are you presently employed? _____ ☐ Unemployed

Military or First Responder employment history: _____ ☐ No history

LEGAL HISTORY Reason:

Are you court ordered for services? ☐ Yes ☐ No _____

Are you involved with a DCF/FFN case or investigation? ☐ Yes ☐ No _____

Do you have any court actions active or anticipated? ☐ Yes ☐ No _____

Have you been arrested in the past two years? ☐ Yes ☐ No _____

STRENTHGS / LIMITATIONS

What strengths do you have that may help us with your counseling plan?

_____

OTHER INFORMATION

_____

_____

ATTESTATION

The information provided on this history form is accurate and complete to the best of my recollective ability.

PATIENT/GUARDIAN SIGNATURE

_____

PROVIDER SIGNATURE

_____

Provider Name, License Signature

Provider Notes