**Lindsay Cooper LAC, LCPC**

410 Central Avenue Suite 308

Great Falls, MT 59401

406-836-7494

What brings you in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been diagnosed with a mental health diagnosis in the past? If so when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been in therapy in the past? If so with whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have been hospitalized for mental health reasons? If so please indicate location and date of stay.\_\_\_\_\_\_\_\_\_\_\_

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Are you disabled? If so what is your disability and when did your disability occur? How long have you been disabled?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol or drugs? If so what and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been a victim or verbal, emotional, physical, or sexual abuse? If so please explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking any medications? [ ] Yes [ ] No If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any allergies? [ ] Yes [ ] No If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you attempted suicide? If so please explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do to take care of yourself or cope with stressful situations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your therapeutic goals?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you would like to share?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**History Information**

Who is providing the history information?

[ ] The client

[ ] The client’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

[  ] Negative thinking

[  ] Change in weight or appetite

[  ] Change in sleeping pattern

[  ] Thoughts of hurting yourself

[  ] Self-harm/Cutting/Burning yourself

[  ] Thoughts of hurting others

[  ] Poor concentration/Difficulty focusing

[  ] Feelings of hopelessness/Worthlessness

[  ] Feelings of shame or guilt

[  ] Low self-esteem

[  ] Anxious/Nervous/Tense feelings

[  ] [Panic attacks](http://www.webmd.com/anxiety-panic/guide/default.htm)

[  ] Racing or scrambled thoughts

[  ] Bad or unwanted thoughts

[  ] Flashbacks/Nightmares

[  ] Muscle tensions, aches, etc.

[  ] Hearing voices/seeing things that are not there

[  ] Thoughts of running away

[  ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[  ] Feelings of frustration

[  ] Perfectionism

[  ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

[  ] Concerns about dieting

[  ] Feelings of loss of control over eating

[  ] Binge eating/Purging

[  ] Excessive exercise

[  ] Job problems

[  ] Other:

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

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Guardian Signature Date

(If Applicable)