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HEARTFELT COUNSELING CENTER, LLC

Client History Form

Please fill out this form completely and bring it to your first session. If you are seeking couples counseling, this form will not be shown to your partner.

Last Name: _____ First Name: _____ Middle Initial___

Name You Would Like to Be Called (Nickname): _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: (_____) _____ May we leave a voice mail message? ☐ Yes ☐ No

Cell/Other Phone: (_____) _____ May we leave a voice mail message? ☐ Yes ☐ No

May we send you text messages? ☐Yes ☐ No

Referred by (if any): _____

SSN: _____ Driver's License No. & State _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Race/Ethnicity: _____

Religious/Spiritual Preference: _____

Sexual Orientation: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Have you previously received any type of individual mental health services (psychotherapy, psychiatric service ,etc.)?

☐ Yes ☐ No If Yes, previous therapist/practitioner: _____

Presenting concerns for previous treatment: _____

_____

Have you previously received couples therapy? ☐ Yes ☐ No If Yes, previous therapist/practitioner:

_____

Was previous couples therapy with current partner or a previous partner? _____

Presenting concerns for previous couples therapy: _____

_____

What made you seek therapy at this time? (current presenting concerns) _____

_____

_____

How much has current presenting concern impacted your daily activities (e.g. work, school, completing tasks around the house, taking care of children, etc).

☐ Not at all ☐ Minimally ☐ Moderately ☐ Significantly

Please explain: _____

_____

How much has current presenting concern (s) impacted your daily functioning (e.g. eating, sleeping, etc)?

☐ Not at all ☐ Minimally ☐ Moderately ☐ Significantly

Please explain: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

Please list all current medications and the physician who prescribed them:

_____

_____

Have you ever been hospitalized **for mental health concerns?** ☐ Yes ☐ No

If yes, please provide details:

Date Location Reason Outcome

_____

_____

_____

ALCOHOL AND DRUG USE:

How many drinks of alcohol do you have in a week? _____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, which ones: _____

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

ABUSE/TRAUMA:

Have you ever been physically/sexually/emotionally abused during your childhood (please circle)? ☐ Yes ☐ No

Alleged abuser(s): _____

At what age(s): _____ Have you ever experienced any other severe trauma? ☐ Yes ☐ No

If yes, explain: _____

Have you been a victim of domestic violence (emotional, physical or sexual) in your adulthood? ☐ Yes ☐ No If yes, explain:

_____

YOUR FAMILY OF ORIGIN:

PARENT

Age: _____ Gender _____ Occupation: _____

Health: _____ If deceased, cause of death: _____

PARENT

Age: _____ Gender _____ Occupation: _____

Health: _____ If deceased, cause of death:_____

Describe your parents' personalities, their relationship with one another and their attitudes toward you (past and present):

_____

_____

SIBLINGS

How many sisters do you have? _____ Ages & Occupations: _____

How many brothers do you have? _____ Ages & Occupations: _____

Please describe your relationship(s) with your sibling(s): _____

_____

Please describe your family dynamics including the atmosphere in the home where you grew up. For example: Was your family unit close, distant, chaotic, loving, cordial, etc.? _____

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any mental health or substance use issues (this can include family of origin and current family unit):

_____

_____

CURRENT RELATIONSHIP/MARRIAGE:

How long have you known your current spouse/partner? _____

Number of years in relationship or marriage: _____

How have you and your partner dealt with the difficulties? _____

How would you describe your current relationship / marriage? _____

_____

How do you get along with your in-laws/partner's family? _____

Please rate your current level of relationship satisfaction by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

How enjoyable is your sexual relationship?

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely pleasant)

Do you perceive that either you or your partner has withdrawn from the relationship?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

CHILDREN FROM CURRENT RELATIONSHIP/MARRIAGE:

Please list any children, their ages and occupations:

_____

_____

Please describe your relationship with your children:

_____

Please describe the family dynamics of your **current** family including the atmosphere in the home. For example: Is your family as a whole close, distant, chaotic, loving, cordial, etc.?

_____

_____

MARRIAGE HISTORY:

Number of marriages: _____

Date of most recent marriage: _____

Age at time of marriage(s): 1st _____ 2nd _____ 3rd _____

Date of recent separation: _____

Date of divorce(s): 1st _____ 2nd _____ 3rd _____

Ages and genders of children from previous relationship (s): _____

YOUR EDUCATION:

Years of education completed: _____ College degree(s): _____

Any learning, behavioral or emotional problems in school or during childhood: ☐ Yes ☐ No

_____

Did you serve in the military? ☐ Yes ☐ No How long? _____ Discharge status: _____

YOUR OCCUPATION:

Are you currently employed? ☐ Yes ☐ No If yes, what is your occupation: _____

Are you satisfied in your work? ☐ Yes ☐ No If no, please explain further: _____

_____

YOUR SOCIAL HISTORY:

How is most of your free time occupied? _____

Interests, hobbies, talents: _____

_____

Clubs/Groups/Church: _____

Are you satisfied with your social life? □ Yes □ No If no, please explain further: _____

_____

LEGAL HISTORY:

Do you have any current or past legal issues (including criminal and civil cases? □ Yes □ No

If yes, please list date, legal issues (e.g. criminal charges, divorce, law suit, etc.) and the outcome:_____

_____

Have you or your current spouse/partner ever been reported to the Department of Children and Families? □ Yes □ No If yes, explain: _____

_____

GOALS:

What would you like to accomplish during your time in therapy? _____

_____

_____

_____ _____

Signature Date Completed