# COUNSELING CONNECTIONS, LLC

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## BACKGROUND INFORMATION (ADULT)

Please complete and bring with you to your first session. If you need help answering the questions or completing the form, we will assist you during your first appointment. Use a separate sheet if additional space is needed. This information will be kept confidential and help us gain a better understanding of your situation.

Date: ______________ Name: ____________________________________ DOB:________________________

### 1. PRESENTING CONCERNS:

(Questions to consider: What do you want to speak to a therapist about? What do you want help with? How long has this been a problem? What happened or changed recently that made you scheduled an appointment for counseling? What are some ways you have tried to fix this? What has helped before? What has not been helpful up to now?)

____________________________________________________________________________________________
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### 2. INITIAL GOAL

(What would you like to accomplish during counseling appointments? What do you hope will be different because of coming to appointments? What goal/s do you want to achieve? What are one or more things that will tell you that you are ready to be finished with counseling for now?) ____________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

### MENTAL HEALTH AND GENERAL HEALTH INFORMATION

3. Have you ever received any type of mental health services before (counseling, psychiatrist, hospitalization, substance abuse program, etc.)? ☐ No ☐ Yes. Please describe, with approximate dates if known. (Use additional sheet if needed)

| Type (in-patient, individual, family, substance abuse, etc.) | Approximate Dates | For how long, or number of session | Diagnosis, if known |
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Name: ____________________________ Chart _________________________

4. Are you currently experiencing any of the following:

| | | | |
|---|---|---|---|
| Overwhelming sadness, crying | ☐Yes ☐No | Suicidal thoughts or wanting to hurt self/another | ☐Yes ☐No |
| Loss of interest in pleasurable activities | ☐Yes ☐No | Change in appetite or sleep patterns | ☐Yes ☐No |
| No energy | ☐Yes ☐No | Unusual change in weight | ☐Yes ☐No |
| Intrusive worry | ☐Yes ☐No | Difficulty turning off troubling thoughts | ☐Yes ☐No |
| Flashbacks, intrusive memories of the past | ☐Yes ☐No | Panic attacks, | ☐Yes ☐No |
| Too much energy, unable to sleep | ☐Yes ☐No | Spending sprees, uncharacteristic behaviors | ☐Yes ☐No |
| Irritability, moodiness | ☐Yes ☐No | Hallucinations (seeing or hearing things) | ☐Yes ☐No |
| Excessive exercising, fearful of gaining weight | ☐Yes ☐No | Binge eating and/or purging | ☐Yes ☐No |
| Other: | | Other: | |

Other symptoms (optional): ____________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

5. MEDICINE: What medicine are you currently taking, including over-the-counter medicine? If appropriate, attach a separate list. The name of the doctor who prescribes the medicine is helpful. ___________________________________________

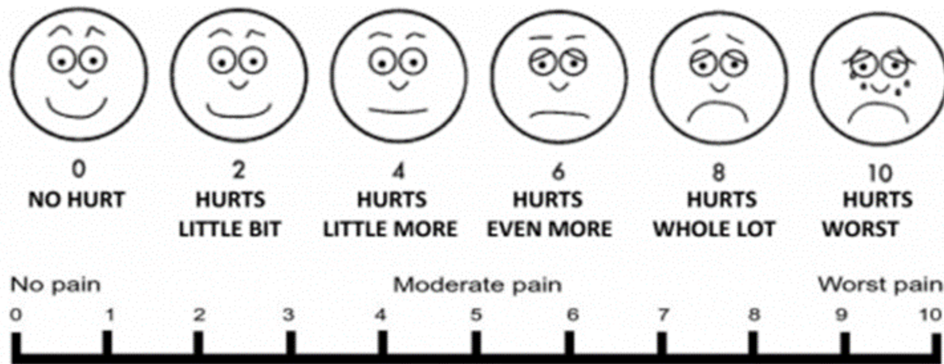
____________________________________________________________________________________________

____________________________________________________________________________________________

6. How would you rate your current physical health? ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good
Please list any specific health problems you are currently experiencing: ___________________________________

____________________________________________________________________________________________

7. Are you currently experiencing any chronic pain? ☐No ☐ Yes. Please indicate severity by marking below.




Please describe/explain: ______________________________________________________________________

____________________________________________________________________________________________

**RELATIONSHIPS**

8. Are you currently in a relationship? ☐ No ☐ Yes. For how long? ____________ ☐ Dating ☐ Engaged ☐Living together
☐ Married ☐Other _______________________ First name of spouse/significant other: ______________________________

9. On a scale of 1-10, with 10 being extremely satisfactory, how would you rate your relationship? __________ Is this better, worse, or about the same as usual? Why?

____________________________________________________________________________________________

____________________________________________________________________________________________

Name: ____________________________ Chart _________________________

10. Briefly describe your relationship history (e.g., number of marriages, divorces, etc.)_________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

11. Children? Other significant people? ______________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

12. What significant life changes, trauma, or stressful events have you experienced recently or in the past: _________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**FAMILY HISTORY**

In the section below, identify if there is a family history of any of the following.

| Issue | Y/N | Relationship to you |
|---|---|---|
| Alcohol/Substance Abuse | ☐Yes ☐No | |
| Anxiety, Panic Attacks | ☐Yes ☐No | |
| Depression, Bi-polar, Manic-Depression | ☐Yes ☐No | |
| Domestic Violence | ☐Yes ☐No | |
| Eating Disorder | ☐Yes ☐No | |
| Obesity | ☐Yes ☐No | |
| Obsessive Compulsive Behavior (OCD) | ☐Yes ☐No | |
| Schizophrenia | ☐Yes ☐No | |
| Suicide Attempts | ☐Yes ☐No | |
| Other: ___________________________ | ☐Yes ☐No | |
| Other: ___________________________ | ☐Yes ☐No | |

13. Describe your family growing up. (Who raised you? Did you move a lot? Were you happy as a child? Number of siblings? What number were you? Use additional space if needed): _____________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**ALCOHOL/OTHER SUBSTANCE USE**

14. Do you drink alcohol more than once a week? ☐ No ☐ Yes; what kinds, how often, and amount: ___________________________
_______________________________________________________________________________________________

15. Do you use tobacco products and/or smoke marijuana (circle) ☐? No ☐Yes; how often and amount: ______________________
_______________________________________________________________________________________________

16. How often do you engage in other recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

17. If you use other recreational substances (cocaine, meth, pills that are not prescribed to you, etc.), what kinds and how often:
_______________________________________________________________________________________________

18. What substances have you experimented with in the past: __________________________________________________________
_______________________________________________________________________________________________

**EMPLOYMENT, MILITARY, LEGAL, ADDITIONAL INFORMATION**

19. Are you currently employed? ☐Yes, where: ____________________________________________________________________
☐No, reason? ____________________________________________________________________________________

Name: ____________________________ Chart _________________________

20. What kinds of work have you done in the past:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

21. Any military experience? ☐No ☐Yes: which branch, when/how long, type of discharge: ______________________________
_______________________________________________________________________________________________

22. Highest level of education completed? ____________ (College major: ___________________________)

23. Any legal issues, or ever arrested or charged with a crime (including DUIs)? ☐No ☐Yes; please describe:
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

24. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes: If yes, describe your beliefs or what, if any, activities you engage in that promote spiritual growth: ______________________________________________________________
_______________________________________________________________________________________________

25. What do you consider to be some of your strengths? What are character traits that you are most proud of?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

26. What do you consider to be some of your weaknesses or character flaws? What would you most like you change about yourself? _________________________________________________________________________________
_______________________________________________________________________________________________

27. Is there anything else that would be good for the therapist to know about you or your situation:

For Office Use Only

Diagnosis (include V/Z codes):

| Order | Code | Name |
| --- | --- | --- |
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Assessments: (GAF) _______________ (GARF) ___________________ (WHODAS) __________________

Plan/FOCUS: