

History Intake

DATE: _____ CLIENT ID# _____
NAME: _____
ADDRESS: _____ CITY: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____
DATE OF BIRTH: _____ AGE: _____ SEX: _____ SS#: _____
RACE: _____ RELIGIOUS AFFILIATION: _____ PRACTICING: YES NO
REFERRED BY: Church _____, newspaper _____, friend: _____
EMPLOYMENT STATUS: Employed Unemployed Retired Student Homemaker Disabled
MARITAL STATUS: Married Divorced Separated Single Live-in partner Widow/widower
LIVING ARRANGEMENTS: Spouse Partner Parent Parents Single Family Friends

NAME OF SPOUSE OR SIGNIFICANT OTHER: _____

PREVIOUS MARRIAGES: 1. _____ When _____
2. _____ When _____
HOW MARRIAGE ENDED: 1. _____ When _____
2. _____ When _____

CHILDREN'S NAMES	DOB	AGE	RESIDING WITH
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

EMPLOYER/SCHOOL	CITY	POSITION/GRADE
1. _____		
2. _____		

PRESENTING PROBLEM: _____

FAMILY OF ORIGIN INFORMATION

Where were you born: _____
 Are you adopted: _____
 Mother's name: _____ What kind of work did she do? _____
 Father's name: _____ What kind of work did he do? _____
 Did your parents divorce: _____ If yes, did they remarry? _____
 Stepfather's name: _____ Stepmother's name? _____

Siblings: (indicate whether full, half, or step)

NAME	RELATIONSHIP	AGE	DOB
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Is there a family history of: (Use additional space if necessary)

_____ Alcoholism	Who _____
_____ Drug Abuse	Who _____
_____ Mental Illness	Who _____
_____ Physical Abuse	Who _____
_____ Sexual Abuse	Who _____
_____ Verbal Abuse	Who _____
_____ Arrests	Who _____
_____ Suicide	Who _____
_____ Suicide Attempts	Who _____
_____ Epilepsy	Who _____
_____ Tourettes	Who _____
_____ Mental Retardation	Who _____
_____ Heart Attacks	Who _____
_____ High Blood Pressure	Who _____
_____ Ulcers	Who _____
_____ Diabetes	Who _____
_____ Cancer	Who _____
_____ Violent Temper	Who _____
_____ Psychiatric Treatment	Who _____
_____ Homicide	Who _____
_____ Foster Care	Who _____

DEVELOPMENTAL HISTORY

A. Birth: Were you premature _____
Complications during pregnancy or delivery _____

B. Neonatal: Baby went home with mother _____
Feeding/behavior problems _____
Birth defects _____
Early separation from parent _____
Rate of development: Walk _____ Talk _____ Toilet trained _____

C. Childhood: Medications _____
Health Problems _____
School Problems _____
Learning Disabilities/Hyperactivity _____
Losses _____
Accidents _____
Firesetting/Cruelty to animals _____

D. Teen School Problems _____
Truancy _____
Jobs _____
First Date _____
First Drove car _____
First sexual experience _____
Sexual acting out _____
Problems with Dad _____
Problems with Mom _____
Problems with the Law _____
First tried Alcohol _____
Problems with Alcohol _____
Problems with Drugs _____
Violence/Aggression _____
Poor Impulse Control _____

SEXUAL ISSUES (Include sexual activity, sexual orientation, use of birth control, sexual abuse, incest, rape, and sexual dysfunction. Risk factors for HIV) _____

PRIOR COUNSELING OR PSYCHIATRIC TREATMENT:

Recent Outpatient: Y N Therapist _____ When _____
Prior Outpatient: Y N Therapist _____ When _____
Prior Inpatient: Y N Facility _____ When _____

PSYCHIATRIC MEDICATIONS: _____

SUBSTANCE USE HISTORY

Have you ever abused drugs or alcohol? Y N

If yes, please describe:

Substance	Amount	Frequency	When (First use; last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has there been substance abuse *treatment* of any kind? Y N

Is there a history of blackouts, seizures, or withdrawal symptoms? Y N

MEDICAL HISTORY

Previous illness history: _____

Current physical symptoms: _____

Family illnesses (serious): _____

Allergies: _____

Menstrual history: _____

Other: _____

ASSESSMENT OF IMPACT ON LIFE ROLES

Indicate how much your current problem(s) has affected the following:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Finances	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Weight Change (in pounds):	Gained:		Lost:			
Sleeping Habits:	1	2	3	4	5	N/A
Insomnia:	Early		Middle		Late	
Sexual Functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

COUNSELING PROCESS

If you were in counseling previously, what issue(s) did you address? _____

If you were in counseling previously, what did you consider to be most helpful? _____

What are your expectations for counseling? _____

Have you had this problem (or this type of problem) before? When? _____

What helped you deal with it then? _____

How can you tell when you are angry? sad? frustrated? _____

How do you get rid of these unpleasant feelings? _____

What happens when this doesn't work? _____

Other information you feel the counselor should know? _____
