Client History Form

NAME: _____ **DATE OF BIRTH:** _____

PERSON(S) PRESENT FOR INTAKE: _____

1. Why are you seeking help now?

What is happening or is different? Did someone refer you for services? If so, for what reason(s)? What stressors do you have? What do you hope will be different by seeking help?

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2. Please give more details about the issue you named above:

When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?

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3. Have you ever experienced similar or other mental health symptoms before?

If so, what was your experience like? When did it happen? Did you get help?

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4. Have you or anyone in your family ever experienced mental health or substance use issues?

If so, who was it? Did your or they seek help or get a diagnosis? What was it like for you or them? What was it like for you? Were you or they hospitalized for psychiatric reasons? If so, when and for how long?

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5. Do you have any current or prior medical issues?

If so, what was/is it? Have you seen a doctor or other healthcare professional for it? What recommendations or treatment did you have? Is there any family history of disease?

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6. Are you currently prescribed any medications?
If so, please list the name, dosage, how often you take it, and the prescriber for each medication.

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7. Please list the name of your primary care physician (PCP) and phone number.

NAME: _____ **PHONE NUMBER:** _____

Do we have your permission to communicate with your PCP and/or prescribing practitioner?

- ☐ **Yes** *(If "Yes" please complete a release of information (ROI))*
- ☐ **No**

8. Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed? How often do you use caffeine?
If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately.

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9. Who is in your family? What is your relationship with them like?
Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

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10. What social activities and relationships do you engage in?
What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

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11. What spiritual practices and cultural influences are important to you?

Do you belong to a religious, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

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12. What was life like as you were growing up, both at home and in school?

Did you meet developmental milestones on time or experience any delays? What are or were your friends like now or when you were younger? What was or is school like for you now?

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13. What significant educational and work/volunteer experiences have you had?

What is the highest level of education you have completed? Are you currently employed? If so, where and for how long? What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)? Are you satisfied with your current employment and education?

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14. Do you have any current or prior legal issues?

Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

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15. What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?

What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

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16. Have you ever thought about or do you now have any thoughts about ending your life?

- ☐ **Yes**
- ☐ **No**

(If "Yes", how frequently do you think about it? Have you ever planned or do you have a plan for how you would do it? Have you told anyone else about these thoughts? What more can you tell us about these thoughts? What is one reason to live?

_____

_____

17. Have you ever thought about or do you now have any thoughts about ending your life?

- ☐ **Yes** *(If "Yes," explain the frequency, intensity and duration of these thoughts?)*
- ☐ **No**

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18. Please check the box for any trauma you may have experienced in the past or present:

- ☐ **Emotional Abuse**
- ☐ **Verbal Abuse**
- ☐ **Physical Abuse**
- ☐ **Sexual Abuse**
- ☐ **Medical Neglect**
- ☐ **Physical Neglect**

Other not listed: _____

_____

19. Please briefly describe below any abuse that you may have checked:

Type of Abuse	Relationship to Abuser	When did it start?	When did it end?	Is it still happening?	Who helped you deal with it?

20. What else is important for the counselor to know about you?'

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Clinical Use ONLY:

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