

EDUCATION

Years of education completed: _____

Currently enrolled in High School/GED? (Y/N) _____ College? (Y/N) _____

Vocational? (Y/N) _____ Graduate School? (Y/N) _____

Other training? (Y/N) _____ If yes, what training

Any Special Circumstances regarding education?

MILITARY

Military experience? Y/N _____ Combat experience? Y/N _____

Where: _____ Branch: _____

Length of service: _____ Type of discharge: _____

Rank at discharge: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

What personal qualities would others say you have?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes _____ No _____

If Yes, where:

Approximate Dates of Counseling: _____

For what reason did you go to counseling? _____

Do you have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy?

What did you find **least helpful** in therapy?

Have you used psychiatric services? Yes ___ No ___

If yes, who did you see? _____

If yes, was it helpful? N/A ___ Yes ___ No ___

Have you taken medication for a mental health concern? Yes ___ No ___

Name of medication	Dates taken	Was it helpful? Y/N

Do you have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe

CHEMICAL USE AND HISTORY

Do you currently use alcohol? ___ Yes, ___ No

If yes, how often do you drink? ___ Daily, ___ Weekly, ___ Occasionally, ___ Rarely

If yes, how much do you drink? _____ (#) per time.

Do you currently use Tobacco? ___ Yes, ___ No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? ___ Yes, ___ No

If yes, what drugs do you use? _____

If yes, how often do you use? ___ Daily, ___ Weekly, ___ Occasionally, ___ Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go? _____

___ Inpatient ___ Outpatient

Adults (please answer the following with Y/N)

1. Have you ever felt you ought to cut down on your drinking or drug use? _____

2. Have you ever had people annoy you by criticizing your drinking or drug use?

3. Have you ever felt bad or guilty about your drinking or drug use? _____

4. Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past. _____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for?

WHEN DID THESE SYMPTOMS FIRST OCCUR? _____

What would you like to see happen as a result of counseling?

What is most concerning right now?

FAMILY HISTORY

What word would you use to describe your family of origin? _____

Are you aware of any birth trauma your mom had during her pregnancy with you, or from age 0-3?

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/Neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

ADDITIONAL INFORMATION

Is there anything else you would like to share:
