

Marital Status (more than one answer may apply)

Single Divorced Unmarried, living together

Length of time: Length of time:

Married Total number of marriages:

Assessment of current relationship (if applicable): Good Fair Poor

Development

Were you raised by person other than parents? Yes No If yes, please explain:

Are there special, unusual, or traumatic circumstances that affected your development?

Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes No

If Yes, which type(s)? Sexual Physical Verbal

If Yes, the abuse was as a: Victim Perpetrator

Other childhood issues: Neglect Inadequate nutrition Other (please specify):

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

Any current or history of being a sexual perpetrator? Yes No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No
If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? Yes No

If Yes, please describe and indicate the court and hearing/trial date and charges: _____

Are you presently on probation or parole? Yes No

If Yes, please describe: _____

Are you hoping to use the therapeutic process in your court proceedings? Yes No

Past History

Traffic violations: Yes No DWI, DUI, etc.: Yes No

Criminal involvement: Yes No Civil involvement: Yes No

If you responded Yes to any of the above, please fill in the following information:

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? Yes No

_____ High school grad/GED

_____ Vocational: Number of years: _____ Graduated: Yes No Major: _____

_____ College: Number of years: _____ Graduated: Yes No Major: _____

_____ Graduate: Number of years: _____ Graduated: Yes No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Military

Military experience? Yes No Combat experience? Yes No

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Inhalants _____
 Caffeine _____
 Nicotine _____
 Over the counter _____
 Prescription drugs _____
 Other drugs _____

Substance of preference

1. _____ 3. _____
 2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication
 ___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol? ___ Yes
 ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No
 If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? If Yes, describe: _____

Does your body temperature change when you drink? ___ Yes ___ No
 If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ___ Yes ___ No
 If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric Treatment	_____	_____	_____	_____	_____

Suicidal thoughts/ Attempts _____
 Drug/alcohol treatment _____
 Hospitalizations _____
 Involvement with self-help groups (e.g., AA, Al-Anon NA, Overeaters Anonymous) _____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss what you consider to be the presenting problem:

What do you hope to achieve through therapy?

Therapist's signature/credentials:

Date:
