

# Spring Tree Counseling

Emotional, Relational, and Mental Well-Being

## Client History

Please complete for each attending person.

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

### GENERAL INFORMATION

Marital Status (circle one):

Single / Engaged      Married      Separated      Divorced      Widowed

Are you a student? Yes\_\_\_ No\_\_\_ Where? \_\_\_\_\_ Area of study: \_\_\_\_\_

Employed? Yes\_\_\_ No\_\_\_ Full Time/Part time \_\_\_\_\_ Employment Date \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

### PRESENTING PROBLEM

Please state in your own words the main reason for seeking counseling.

On the scale below, please estimate the severity of your problems:

Mildly                      Moderately                      Very                      Extremely                      Totally  
Upsetting\_\_\_\_      Upsetting\_\_\_\_      Upsetting\_\_\_\_      Upsetting\_\_\_\_      Upsetting\_\_\_\_

Have you been in counseling before or received any professional assistance for these or other problems? If so, please give names, professional titles, dates of treatment and results.

Have you ever experienced suicide ideation? Yes\_\_\_No\_\_\_ Have you ever attempted suicide? Yes\_\_\_No\_\_\_

Comments:

Have you ever been hospitalized for psychological problems? Yes\_\_\_No\_\_\_ If yes, when and where?



**SYMPTOMS**

Please check how often these symptoms occurred *in the last six months*. If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months*.

Symptom	Never / Rarely	Few times / month	Nearly every day	Symptom	Never / Rarely	Few times / month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Food preoccupation				Stomach problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

**MEDICAL ISSUES**

Medications or other medical issues (allergies, thyroid, diabetes, etc.) we should know about: