

Emotional, Relational, and Mental Well-Being

Client History

Please complete for each attending person.	
Client's Name: 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 Employer Occupation	Employment Date
PRESENTING PROBLEM Please state in your own words the main reason for see	eking counseling.
On the scale below, please estimate the severity of you Mildly Moderately Very Upsetting Upsetting Upsetting	Extremely Totally
Have you been in counseling before or received any proplease give names, professional titles, dates of treatments	rofessional assistance for these or other problems? If so, ent and results.
Have you ever experienced suicide ideation? YesN	No Have you ever attempted suicide? YesNo
Comments:	
Have you ever been hospitalized for psychological prob	olems? Yes No If yes, when and where?

PERSONAL AND SOCIAL HISTORY

Please list all of your immediate family members, including, parents, siblings, spouses, and children. For those deceased, please give date and cause of death.

Name	Relationship	Sex (M/F)	Age	Living / Deceased	If Deceased, Date and Cause of Death

SOCIAL RELATIONSHIPS Check how you generally get along with other people: (check all that apply) Affectionate Aggressive AvoidantFight/argue oftenFollower FriendlyLeaderOutgoingShySubmissiveOther (specify) Sexual orientation: Comments:
CULTURAL/ETHNIC
To which cultural or ethnic group, if any, do you belong?
Are you experiencing any problems due to cultural or ethnic issues?YesNo
If Yes, describe:
Other cultural/ethnic information:
SPIRITUAL / RELIGIOUS
How important to you are spiritual matters?Not at all LittleModerateMuch
Are you affiliated with a spiritual or religious group?YesNo
If Yes, describe:
Would you like your spiritual/religious beliefs incorporated into the counseling?YesNo
If Yes, describe:

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				Emotional abuse of			
work/school				self or others			
Stealing				Other:			

MEDICAL ISSUES

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