CLIENT HISTORY FORM

Name: _____

1. **GOALS**: What would you like to accomplish coming here? _____

   _____

   a. Have you discussed your concerns/goals with anyone previously? ___ Yes ___ No
   If so, whom? _____

2. **PRODUCTIVITY:** I feel very satisfied with my productivity level at work and in personal life (circle one word for each)
   - At **Work**: Strongly Agree (5) Agree (4) Neutral (3) Disagree (2) Strongly Disagree (1)
   - At **Home**: Strongly Agree (5) Agree (4) Neutral (3) Disagree (2) Strongly Disagree (1)

3. **HARM:** Have you considered suicide or harming another? ___ Yes ___ No | Abuse/Trauma History ___ Yes ___ No
   If yes: ___ suicide ___ harm to another (state who/relationship_____)
   Method_____ When_____

4. **CURRENT FINANCIAL/LEGAL SITUATION**: My finances are: ___ stable ___ tight ___ in trouble ___ just right
   a. Have you ever had any trouble holding a job due to legal concerns? ___ Yes ___ No
   Comments: _____

   b. Do you have any pending legal actions or history of legal problems (arrests, DUI's, convictions)? ___ Yes ___ No
   Comments: _____

5. **SUBSTANCE USE AND ADDICTION HISTORY:**
   a. Does alcohol, drugs, or other addictive behaviors cause problems in your life? ___ Yes ___ No ___ N/A
   If yes, indicate: ___ alcohol ___ prescription drugs ___ illicit drugs ___ sex ___ gambling
   ___ internet ___ shopping ___ nicotine ___ other ____ N/A

   over

   Mark areas affected by above: ___ work ___ relationships ___ family ___ personal health

   c. Have others ever suggested that you have a problem with substance use or other addictions? ___ Yes ___ No
   Comments: _____

   d. Does anyone have an addiction or problem other than you (be specific): _____

6. **HEALTH HISTORY: Overall health status**: ___ Excellent ___ Good ___ Fair ___ Poor
   Physician Name(s)/specialties: _____
   a. List physician prescribed medications, over-the-counter-medicines, or herbs you currently use:

   _____

   b. Please indicate any medical conditions/health issues that you have or are currently experiencing:

   _____

   c. Check all that apply: ___ difficulty falling asleep ___ wake frequently in the night ___ feel well rested
   ___ experience nightmares ___ use sleep aids ___ wake early ___ decreased appetite ___ increased appetite

   d. Mental health history (list any history of counseling, in-patient, out-patient treatment):

   _____

   _____

7. **MILITARY HISTORY**: Have you served in the military? ___ Yes ___ No If yes, which branch _____
   a. Active duty experience? ___Yes ___ No If yes, dates of service _____
   b. Describe your experience: _____

_____

Client Signature **Date**

CLIENT HISTORY FORM

Abuse / Addiction of Client
- ___Alcohol Abuse
- ___Drug Abuse
- ___Gambling
- ___Internet
- ___Sexual
- ___Abuse Other

Family
- ___Family Conflict
- ___Child
- ___Teen
- ___Parent / Child Relationship
- ___Domestic Violence
- ___Reaction to Illness
- ___Living with Abuse or Addiction
- ___Living with Emotional Problem
- ___Family Other

Marital / Relationship
- ___Marital / Relationship

Emotional Problems
- ___Depression
- ___Anxiety
- ___Grief
- ___Stress
- ___Emotional Other

Trauma and Abuse
- ___Physical Abuse
- ___Sexual Abuse
- ___Emotional Abuse
- ___Post Traumatic Stress
- ___Trauma Other

Work Related
- ___Relationship with co-workers
- ___Relationship with Supervisor
- ___Work Place Violence
- ___Harassment
- ___Job Performance
- ___Work Related Other

Medical Condition
- ___Medical Condition

Financial
- ___Financial Planning
- ___Debt
- ___Financial Other

Legal
- ___Legal

Work / Life Balance
- ___Childcare
- ___Older Adult Services
- ___Lifestyle / Wellness
- ___Consumer Issues
- ___Travel / Recreation
- ___Home Repair
- ___Pet Care
- ___Education
- ___Work Life Other

Other
- ___Anger
- ___Communication Skills
- ___Eating Disorders
- ___Smoking Cessation
- ___Time Management
- ___Weight Management

If not listed, fill in:

_____

_____

Check the presenting concerns/areas you would like to discuss: