Client Name: ____ Date: ________________

Religious/Spiritual Preference (if any): ____

Highest Level of Education: ____

Occupation: ____

Current Employment Status: ____

FAMILY INFORMATION

Relationship status:

____

____

List all people living in your household:

Name	*Age*	*Gender*	*Relationship to Client*
______________________	___	_____	______________________
______________________	___	_____	______________________
______________________	___	_____	______________________

List any children <u>not</u> living in your household:

Name	*Age*	*Gender*	*Relationship to Client*
______________________	___	_____	______________________
______________________	___	_____	______________________
______________________	___	_____	______________________

GENERAL HEALTH INFORMATION

How would you rate your current health?

Poor *Unsatisfactory* *Satisfactory* *Good* *Very Good*

Please list any specific health problems you are currently experiencing.

____

____

____

____

Are you currently taking prescription medication for your physical health? If yes, please list the medication and dosage below.

____

____

____

MENTAL HEALTH INFORMATION

Have you previously received any mental health services? If yes, please list when you had services and with whom.

Are you currently taking prescription medication for your mental health? If yes, please list the medication and dosage below.

FAMILY MENTAL HEALTH HISTORY

Relationship to client	Diagnosis

Are you having thoughts of harming yourself? If yes, please explain below.

Presenting Problem (Why are you seeking counseling services?)

What would you like to accomplish in counseling?

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = day functioning

	None	Mild	Moderate	Severe
Depressed mood	[ ]	[ ]	[ ]	[ ]
Sleep disturbance	[ ]	[ ]	[ ]	[ ]
Fatigue/low energy	[ ]	[ ]	[ ]	[ ]
Physical complaints	[ ]	[ ]	[ ]	[ ]
Poor concentration	[ ]	[ ]	[ ]	[ ]
Paranoia	[ ]	[ ]	[ ]	[ ]
Hallucinations	[ ]	[ ]	[ ]	[ ]
Aggression	[ ]	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]	[ ]
Feeling hopeless	[ ]	[ ]	[ ]	[ ]
Feeling worthless	[ ]	[ ]	[ ]	[ ]
Social withdrawal	[ ]	[ ]	[ ]	[ ]
Compulsions	[ ]	[ ]	[ ]	[ ]
Guilt	[ ]	[ ]	[ ]	[ ]
Hyperactivity	[ ]	[ ]	[ ]	[ ]
Appetite changes	[ ]	[ ]	[ ]	[ ]
Weight loss/gain	[ ]	[ ]	[ ]	[ ]
Self-injury	[ ]	[ ]	[ ]	[ ]
Memory problems	[ ]	[ ]	[ ]	[ ]
Mood swings	[ ]	[ ]	[ ]	[ ]
Grief/loss	[ ]	[ ]	[ ]	[ ]
General anxiety	[ ]	[ ]	[ ]	[ ]
Social anxiety	[ ]	[ ]	[ ]	[ ]
Panic attacks	[ ]	[ ]	[ ]	[ ]
Phobias	[ ]	[ ]	[ ]	[ ]
Social isolation	[ ]	[ ]	[ ]	[ ]
Obsessions	[ ]	[ ]	[ ]	[ ]