Positive Mind Counseling, LLC

Client History Form

Date:_________________

Who is completing this form?

[ ] Client [ ] Parent/Guardian [ ] Other:________________________

PRESENTING PROBLEM:

What brought you to therapy today? In your own words, describe your current complaint or problem.

How long has this problem been present in your life? When did you first notice it? How often does it occur?

What goals would you like to focus on in therapy? What is that you are looking to change about yourself?

What are some of your strengths and protective factors? What do you do well? Who are your supports?

Please check off any symptoms/problems that apply to you currently or previously:

Symptoms/Problems	Current	Previously
Anger/Irritabilty	[ ]	[ ]
Depression/Sadness/Feeling down	[ ]	[ ]
Mood Swings	[ ]	[ ]
Mania/High feelings	[ ]	[ ]
Anxious/Nervous/Tense feelings	[ ]	[ ]
Panic Attacks	[ ]	[ ]
Somatic Complaints	[ ]	[ ]
Low Motivation	[ ]	[ ]
Crying Spells	[ ]	[ ]
Difficulty Focusing/Easily Distracted	[ ]	[ ]
Disorganized	[ ]	[ ]
Isolative/Withdrawn	[ ]	[ ]
Substance abuse/dependence	[ ]	[ ]
Alcohol abuse/dependence	[ ]	[ ]

Difficulty enjoying things	[ ]	[ ]
Negative thinking	[ ]	[ ]
Feelings of hopelessness	[ ]	[ ]
Eating problems	[ ]	[ ]
Loss of interest in things	[ ]	[ ]
Binge eating/eating disorder	[ ]	[ ]
Sleep problems	[ ]	[ ]
Flashbacks/Nightmares	[ ]	[ ]
Scrambled thoughts	[ ]	[ ]
Paranoid thoughts	[ ]	[ ]
Intrusive thoughts	[ ]	[ ]
Suicidal thoughts	[ ]	[ ]
Homicidal thoughts	[ ]	[ ]
Self-injurious behavior (e.g. cutting/burning)	[ ]	[ ]
Oppositional/Defiant Behavior	[ ]	[ ]
Argumentative	[ ]	[ ]
Unresolved Grief/Loss	[ ]	[ ]
Shame/Guilt	[ ]	[ ]
Low self-esteem	[ ]	[ ]
Perfectionism	[ ]	[ ]
Rituals of counting, cleaning etc.	[ ]	[ ]
Change in weight or eating habits	[ ]	[ ]
Poor self-image	[ ]	[ ]
Body image issues	[ ]	[ ]
Excessive Exercise	[ ]	[ ]
Lack of confidence	[ ]	[ ]
Problems with Gender	[ ]	[ ]
Problems with sexuality	[ ]	[ ]
Marital conflict	[ ]	[ ]
Infertility	[ ]	[ ]
Parenting Concerns	[ ]	[ ]
Hallucinations: seeing/hearing things not there	[ ]	[ ]
History of child abuse	[ ]	[ ]
History of sexual abuse	[ ]	[ ]
Witness/Experience trauma	[ ]	[ ]
Victim of Domestic Violence	[ ]	[ ]
History of Suicide attempts	[ ]	[ ]
Job issues/Unemployment	[ ]	[ ]

TREATMENT HISTORY:

Have you ever attended therapy or received psychiatric treatment anywhere else? (Counseling/PHP/IOP/Hospitalzations etc)

[ ] Yes [ ] No

If YES, please complete the location and approximate dates of previous treatment:

Location?	When?	Treated For?
Location?	When?	Treated For?
Location?	When?	Treated For?

If YES, what was helpful or not helpful during your previous treatment experiences?

DEVELOPMENTAL HISTORY

Did you meet all developmental milestones on time? (e.g walking, talking, toileting)
[ ] Yes [ ] No
If yes, Explain:

Were there any complications during your mother's pregnancy with you or during birth?
[ ] Yes [ ] No
If yes, Explain:

Have you completed other milestones/transitions in your life that you are satisfied with? (e.g school, career, relationships, children, finances)
[ ] Yes [ ] No
If no, Explain:

HEALTH/MEDICAL HISTORY

Are you currently taking any medications? Please list below Name, dosage, frequency:

Current Prescriber:_______________________ PCP:________________________

Date of last physical: __________________ Rate current physical health: Poor Fair Good Excellent

Do you have a history of serious illnesses from childhood?
[ ] Yes [ ] No
If yes, Explain:

Do you have any health concerns, medical conditions, serious illnesses, or undergone any major hospitalizations?
[ ] Yes [ ] No
If yes, Explain:

FAMILY/SOCIAL HISTORY

Where were you born?

Who do you identify as your parental figures? What is the nature of that relationship currently or previously?

Sibling(s) and current relationship status:
Sister/Brother name: _____________________________ Age: ____
Relationship quality:____
Sister/Brother name: _____________________________ Age: ____
Relationship quality:____
Sister/Brother name: _____________________________ Age: ____
Relationship quality:____

Family history of mental health and substance abuse:

Describe your childhood/adolescent years. (Attitude, feelings, dis/likes, etc.)

Please describe any history of verbal, physical, or sexual abuse that you may have encountered:

Do you have a history of significant losses?

Please describe your social support system:

What is your current living arrangement?

Sexual Orientation:____
Current relationship status: ____
If currently partnered, quality of relationship:____________________________________

How many children do you have? Natural: ________ Adopted: ________ Stepkids:_________ Foster:_______
Child's Name: _________________________Age: _____
Relationship quality: ____

Child's Name: _________________________Age: _____
Relationship quality: ____
Child's Name: _________________________Age: _____
Relationship quality: ____

Are there any current legal issues in regards to your children such as custody, guardianship, etc? Has DCF ever been involved with your family previously or currently?

DCF Worker:___________________________ Office Location:________________ Phone: ________________

EDUCATIONAL HISTORY

What is the highest level of education that you completed?

What was your experience while in school?

Did you attend any special education classes or receive any special services?

Were there any behavioral/attendance concerns while attending school?

OCCUPATIONAL HISTORY

Are you currently employed?
[ ] Yes [ ] No
If yes, please describe:

If no, please describe:

Do you feel satisfied with your employment? If not, please describe:

Have you ever been or are you currently part of the Military? What branch and when? Did you experience any trauma or witness any traumatic events?

SUBSTANCE USE/ABUSE HISTORY

Describe your personal history of substance use. How often? How much?
Caffeine:________________ Nicotine:_______________ Alcohol:________________
Other:__________________

Have you received treatment for any of the above substances? [ ] Yes [ ] No

If yes, when, for what substance and for how long?

Do you currently have concerns about alcohol or substance use? [ ] Yes [ ] No
If yes, please describe:

LEGAL HISTORY

Do you have any current or a history of legal issues? [ ] Yes [ ] No
If Yes, please answer the following:

Please describe any arrests, charges, convictions, and/or incarcerations.

Are you currently on probation? [ ] Yes [ ] No

Probation Officer:___________________ Office Location:________________ Phone:___________________

ADDITIONAL INFORMATION

Is there any other information that you believe would be helpful to your therapeutic experience? Please use space below to include any other information not noted above. Thank you!