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SproutCounseling

PERSONAL & FAMILY HISTORY

Client Name: _____ Age:_____

Sex: _____ Ethnicity:_____ Marital Status: _____

Current Employer: _____ Occupation: _____

Highest Level of Education:_____

		If living		If Deceased	
	Name	Age	Health	Year & Age	Cause
Father					
Mother					
Brother(s)					
Sister(s)					
Spouse					
Son(s)					
Daughter(s)					
Other: (Step-parents, children)					

MEDICAL HISTORY

Are you taking any medicines, drugs, herbs, over-the-counter medications, or vitamins?
Yes ___ No ___

If so, list by name and dose. Be SURE to include medicine for: heart, blood pressure, thyroid, pain, sleep, nervousness, depression, epilepsy, birth control, weight reduction or hormones:

Medical Hospitalizations (list illness, year, and physician):

Surgical Hospitalizations (list illness, year, and physician):

Other serious illnesses or injuries:

Previous psychiatric and/or counseling treatment (practitioner, year, type of treatment, and medication, purpose):

Current Stressors:

Reason for seeking counseling (major problem):

How have you addressed these concerns already?

Have you had any of these experiences in the past 3 months?

	Yes	No
Depressed mood?		
Loss of interest?		
Loss of pleasure?		
Excessive fatigue?		
Loss of appetite?		
Thoughts of self harm?		
Thoughts of harming others?		
Trouble concentrating?		
Weight gain?		
Weight loss?		
Agitation?		
Feelings of unreality?		
Inappropriate elation?		
Inappropriate irritability?		
Grandiose notions?		
Increased pressured speech?		
Disconnected, racing thoughts?		
Markedly increased energy?		
Distractibility?		
Impulse control problem?		
Low self-esteem?		
Nervous habits?		
Social withdrawal?		

	Yes	No
Sleep disturbance?		
Panic attacks?		
Excessive muscle tension?		
Excessive nervousness?		
Difficulty breathing/smothering?		
Feeling very slowed down?		
Dizziness/Faintness?		
Tremors?		
Sweating?		
Tingling/Numbness?		
Flushes/Chills?		
Fear of losing control?		
Hallucinations (seeing or hearing things)?		
Suspiciousness of several people?		
Overly rapid/Skipping heartbeat?		
Difficulty remembering/Mind going blank?		
Unwanted recurrent persistent thoughts?		
Repetitive behavior or mental acts that you feel driven to perform?		
Behaviors or thoughts aimed at warding off some dreaded event?		
Confusion?		
Wide mood swings?		

More specific Information you would like for me to know?

_____
_____
_____
_____
_____
_____

What would you like to accomplish through counseling?

_____
_____
_____
_____
_____
_____