

GENERAL AND MEDICAL HISTORY

Client Name: _____ Date of Intake: _____

FAMILY AND SOCIAL HISTORY:

Relationship Status: (circle): Single Living with Significant Other Engaged Married Divorced Widowed

Brief description of family life: Normal / Troubled / Abused / Broken Family Unit / Intact Family Unit

Partner's Name: _____ DOB: _____

His/Her Occupation: _____

Length of Current Relationship: _____

Persons Living in Your Home

Name of Person	Age	Relationship	Occupation/Grade

Children Not Living In Your Home

Name of Person	Age	Relationship	Occupation/Grade

Previous Marital History:

From Date	To Date	How Ended	# of Children

Father: Living/Deceased/Married/Separated/Widowed

Mother: Living/Deceased/Married/Separated/Widowed

MEDICAL INFORMATION:

Reason for today's visit: _____

Describe your health (Circle): Excellent Very Good Good Fair Poor

Do you have any allergies/medication allergies? If yes, explain: _____

List any medical problems you are currently being treated for by a physician:

Name of primary care physician: _____

Address: _____

Do you have any major medical conditions in your family history: If yes, please explain:

MENTAL STATUS:

Do you feel suicidal today? _____ If yes, how long have you been feeling suicidal? _____

Do you have a plan? _____ If yes, please explain: _____

Have you had unsuccessful attempts of suicide? _____ If yes, how long ago? _____

Have you threatened suicide without any attempts? _____ If yes, how many times? _____

Are you having homicidal thoughts **today**? If so, please describe:

Have you had any homicidal thoughts in the **past**? _____ If so, please describe:

Have you made recent threats against another person? _____ If so, please describe:

PREVIOUS COUNSELING:

Name of Therapist	Dates: FROM-TO	Problem	Was it Helpful?

MEDICATIONS:

Name of Medication	Dosage/Frequency	How Long?	Prescribing Doctor

Do you drink coffee, tea, soft drinks or other products containing caffeine? YES NO
Do you smoke or use other tobacco products? YES NO
Do you drink beer, wine or distilled spirits? YES NO

SUBSTANCE ABUSE:

Do you currently use alcohol, cannabis or other illicit drug? If yes, please explain:

How long have you been using substance? _____

Do you have a history of substance abuse? If yes, please explain:

How long did you use substance? _____

RELIGIOUS AFFILIATION:

Do you have a religious affiliation or domination? If so, please complete:
