EVOLVE COUNSELING & HOLISTIC WELLNESS, LLC©

GENERAL AND MEDICAL HISTORY

Client Name:_____ Date of Intake: _____

FAMILY AND SOCIAL HISTORY:

Relationship Status: (check): 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 elicit 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:

_____