CLIENT HISTORY

General:

Name _____ Date_____

Address _____ Home phone _____

Cell phone _____ Work phone _____

E-mail _____ Referred by _____

Date of birth _____ Age _____

Gender Identification _____ Educational level _____

Occupation _____ Employer _____

Children's names/ages

_____

_____

Who lives with you in your home? _____

Relationship status _____

Sexual orientation _____ Ethnic/Cultural identity _____

In the event of an emergency I give my permission for Deborah Haarstad, LMFT to contact any of the following people:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone _____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s), address(es), telephone number(s) _____

_____

Have you ever been hospitalized for mental or emotional problems? _____

If so, please describe _____

List all current prescription medications? _____

How long have you been on the medications? _____

List all other medications/dosages your currently take including over-the-counter, supplements, medical marijuana, etc _____

_____

Have you ever attempted suicide? _____ If so, when? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

_____

Have you experienced any trauma in your life? If so, please describe _____

_____

_____

What are your current stressors? _____

What are your strengths and resources? _____

_____

Describe your support network? _____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe_____

_____

_____

Describe your current health or any health concerns you currently have?_____

_____

_____

Are you experiencing any difficulties with sleep, appetite or eating? _____

Do you exercise?_____ Type and frequency _____

Do you smoke? _____ How much? _____ How long? _____

Have you ever suffered a head injury? ____ If so, was there loss of consciousness? _____

Have you ever been in a 12-step program? Please describe. _____

_____

Do you drink alcohol? _____ How many days of the week? _____

On average, how much alcohol do you consume in a week? _____ Have you ever wanted to drink less or less often or tried to cut back? _____

Do you currently use illegal drugs? Please describe your use _____

_____

Have you ever used illegal drugs? Please describe. _____

_____

Additional information:

Mother's name, living/deceased, patient's age at the time of mother's death _____

_____

Father's name, living/deceased, patient's age at the time of father's death _____

_____

Names and ages of siblings. _____

_____

Current/past spiritual practice _____

Have you ever been in a lawsuit? If yes please describe. _____

Areas of Concern

What issues/problems are of most concern right now? _____

_____

_____

_____

Do you have any specific goals with regard to these issues?_____

_____

_____

_____

What behaviors do you wish to change? _____

_____

_____

_____