Mindwise Counseling
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Client History and Background Form

Your honesty aids my work in terms of integrating themes and current life functioning. Thank you for your time in filling out this form.

Client's full name: _____ Date: _____

Client's Social Security #_____ Age _____ Gender __F __M

Address_____ City _____State_____Zip_____

Telephone_____ work_____ cell_____

Birthdate ___/____/_____ Race/Ethnicity_____

Emergency Information

In case of emergency, please contact:
Name_____ Relationship_____
Phone_____ Address_____

Employment Information

Client: Place_____ Occupation_____ Hrs_____

Referral Source

How did you hear about my services? _____
Do you (client) have a: ___conservator ___guardian ___representative payee
____No ____Yes Name_____ Phone_____
Address_____

Primary Reason for seeking services:

___Anger Management
___Anxiety
___Fears or Phobias
___Coping
___Mental Confusion
___Alcohol/Drugs
___Depression
___Sexual Concerns
___Eating Disorder
___Sleeping problems
___Other mental health or behavioral concerns

How long have you been experiencing these problems? _____

Please check behaviors and/or symptoms that occur to you more often than you would like them to:

___Aggression
___Alcohol dependence
___Anger
___Antisocial behavior
___Anxiety
___Avoiding people
___Chest Pain
___Computer Addiction
___Depression
___Disorientation
___Distractibility
___Dizziness
___Drug Dependence
___Eating Disorder
___Elevated Mood
___Fatigue
___Gambling
___Hallucinations
___Heart palpitations
___High Blood Pressure
___Hopelessness
___Impulsivity
___Irritability
___Judgment errors
___Loneliness
___Memory Impairment
___Mood Shifts
___Panic Attacks
___Phobias/fears
___Recurring thoughts
___Sexual Addiction
___Sexual Difficulties
___Sick Often
___Sleeping problems
___Speech problems
___Suicidal Thoughts
___Thoughts disorganized
___Trembling
___Withdrawing
___Worrying
___Other (specify_____)

What areas of your life are affected by the above?

Social
___Unable to form or maintain friendships
___Withdrawal from family and friends
___Increased conflict with others
___Loss of interest in social activities
___Phobias

Occupational
___Unable to maintain job
___Absenteeism
___Conflicts with co-workers
___Tardiness
___Reduced Productivity
___Disciplinary Action for Poor Performance

Academic
___failing grades
___truancy
___tardiness
___detention
___reduced productivity at school
___fighting/conflicts with students/teachers

Affective Distress/Physical
___crying spells
___mood swings
___anger/rage
___disorganized thoughts
___feeling overwhelmed with emotions
___worrying that interferes with the ability to concentrate
___memory problems
___concentration problems

___decreased energy/fatigue
___difficulty getting out of bed or insomnia
___decreased/increased appetite
___substantial weight loss or gain
___physical complaints (headaches, stomachaches)
___frequent illness

Development
Has there been any history of child abuse _____yes _____no
If yes, which type(s)? _____sexual ____physical _____ verbal
Other issues ____neglect ___inadequate nutrition ___poor health
___other (please specify)_____

Do you currently have supportive friendships? ___yes ___no

Sexual Orientation_____
Sexual Dysfunctions? ___yes ___no

Cultural/Ethnic
To which cultural or ethnic group, if any, do you belong?_____
Are you experiencing any problems due to cultural/ethnic issues? ___yes ___no
If yes, please describe_____

Spiritual/Religious
How important to you are spiritual matters? ___not at all ___little ___moderate ___much
Are you affiliated to a spiritual/religious group? ___yes ___no
Which one?_____
Would you like your spiritual/religious beliefs incorporated into the counseling? ___yes ___no

Current and Past Legal Status
Are you involved in any active cases (civil or criminal)? ___yes ___no
If yes, please describe and indicate the court and hearing/trial dates and charges_____
Are you presently on probation or parole? ___yes ___no
Please list any previous criminal or civil charges_____

Personal History of:

	Currently	**In the Past**	**Never**
Alcohol Abuse			
Depression			
Drug Abuse			
Bipolar			
Suicide Attempt			
Nervousness			
Psychiatric Hospitalization			

Family History of:

	Currently	**In the Past**	**Never**

Alcohol Abuse_____
Depression/Anxiety _____
Drug Abuse _____
Bipolar _____
Suicide Attempt_____
Psychiatric Hospitalization _____

Current and Past Health Concerns
Please list any current health
concerns_____
Do you have any disabilities? ___no ___yes If yes, describe and note how it affects your physical
and/or psychological functioning and how you adjust to your disability_____
_____

Chemical Abuse History
Please check which substances you have used in the past:
___alcohol ___barbiturates ___Valium/Librium ___Cocaine/Crack ___Heroin/Opiates ___marijuana ___PCP/LSD ___Inhalants ___Caffeine ___Nicotine ___Over the counter ___prescription drugs ___other

Are you using any of these substances currently? ___yes ___no If yes, which ones?_____
_____
How often?_____ Use in the last 48 hours?_____ In last 30 days?_____
Explain_____
Have you ever had any withdrawal symptoms when trying to stop using drugs or alcohol?
____yes ____no Please describe_____
Have drugs ever created a problem for your job? ____yes ___no If yes, please describe__
_____

Prior Counseling/Psychiatric Treatment
Have you had previous treatment? ___yes ___no If yes, please describe your experience
_____
_____
Any previous mental health diagnoses? _____
What are your goals for therapy?_____
Do you feel suicidal at this time? ____yes ____no If yes, explain_____
_____

How may I contact you? US mail ___ Phone ____ email: please provide email address:
_____

Client's signature_____ Date_____

Parent/Guardian (If applicable)_____ Date_____

Therapist's signature/credentials_____Date_____