FRIENDS COUNSELING

CLIENT HISTORY

(PSYCHOLOGICAL, SOCIAL, PHYSICAL and SPIRITUAL)

Name_____
Last First Middle Date

Completed by: _____ *If not client, relationship to client:*_____

Reason for Seeking Counseling:_____

Sex: [ ] Male [ ] Female *Place of Birth:*_____

Race: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other (Specify):_____

Are you currently or have you ever been married? [ ] N/A [ ] Yes [ ] No *If yes, how many times have you been married?*_____

Current marital status: [ ]Single [ ]Married [ ]Separated [ ]Divorced [ ]Widowed *Number of children:* _____

List all persons currently living in client's household:	**List children <u>not</u> living in same household as client:**
Name Age Sex Relationship to client	Name Age Sex Relationship to client
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
	Frequency of visitation of above: _____

<u>Educational Information</u>

Grade: _____ [ ]9 [ ]10 [ ]11 [ ]12 *Please indicate the highest level of education attained:* _____

<u>Degree</u>	**<u>Field</u>**	**<u>College/University</u>**
Bachelor [ ] Yes [ ] No	_____	
Masters [ ] Yes [ ] No	_____	
Doctorate [ ] Yes [ ] No	_____	

<u>Employment History</u>

What is your current employment status? [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

[ ] Homemaker If employed, where are you currently employed? _____
Your current occupation is:

_____

How long have you been employed there and what do you do?_____
Previous employment in the past five years: _____
Employment Satisfactory? [ ]Yes [ ] No If no, why? _____

Social/Lifestyle/Medical History

Symptom Checklist (rate your symptoms at their current level)

None: This symptom is not present at this time
Mild: Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate: Significant impact on quality of life and/or day-to-day functioning
Severe: Profound impact on quality of life and/or day-to-day functioning

Symptoms	None	Mild	Moderate	Severe	Symptoms	None	Mild	Moderate	Severe
aggressive behaviors					hopeless				
agitation					hyperactivity				
alcohol to excess					irritability				
anorexia					laxative/diuretic abuse				
anxiety					mood swings				
appetite disturbance					obsessions/compulsions				
bingeing/purging					panic attacks				
conduct problems					paranoid thoughts				
confused thinking					physically hurt others				
defiant behavior					physically hurt self				
depressed mood					victim of physical harm				
drug abuse					poor concentration				
elevated mood					poor grooming				
excessive fears					sexual dysfunction				
hear strange voice					sexually harmed others				
fatigue/low energy					seeing strange things				
overemotional					significant weight gain/loss				
social isolation					sleep disturbance				

grief					emotionally harmed others				
guilt					suicidal thoughts				
bowel/bladder disturbance									

What medications are you currently taking?

Medication & Dosage:_____ Frequency: _____ Physician: _____
Reason for Medication:_____

Medication & Dosage:_____ Frequency: _____ Physician: _____
Reason for Medication:_____

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

Health Concerns	Self	Family		Health Concerns	Self	Family
Allergies				Alzheimer's/Dementia		
Birth Defects				Bronchitis/Asthma		
Cancer				Diabetes		
Caffeine Use/Abuse				Ear Infections/Tubes		
Food Sensitivities				Falls/Accidents		
Emotional/Behavioral Problems				High Blood Pressure		
Heart Disease				Stroke/Coma		
Tyroid Problems				Tuberculosis		
Tobacco Use				Orthopedic Problems		
Alcoholism/Drug/Abuse				Ulcers		
Concussion/Broken Bones				Other Chronic/Serios Health Problems		

Family History

Father:
Full Name: _____
Occupation:_____
Education:_____
General Health: _____
If father is deceased: How many years and age of client at father's death: _____

Mother:
Full Name: _____
Occupation:_____
Education:_____
General Health: _____
If mother is deceased: How many years and age of client at mother's death_____

Parents' current marital status:

_____ married to each other
separated for___ years
divorced for____ years
mother remarried_____times
father remarried_____ times

Present during childhood:

Family Member	Present	Present Part Of	Not Present
mother			
father			
stepmother			
stepfather			
brother(s)			
sister(s)			
other (specify)			

List Siblings (Brothers & Sisters): _____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others
other _____
Client's age at leaving childhood home: _____ Circumstances:

_____
Special circumstances in childhood: _____
Describe any past or current significant issues in other immediate family relationships:

_____
Describe any past or current significant issues in intimate (e.g. spousal) relationships:

_____

Do you, the client, have a history for any of the following?

Social Concerns	Yes	No	Social Concerns	Yes	No
Chronic Lying			Night Terrors		

Stealing			Distrustful		
Violent Temper			Extreme Worrier		
Fire Setting			Self-Injurious Acts		
Won't Sleep Alone			Impulsive		
Repeats Words or phrases			Easily Distracted		
Not Trustworthy			Poor Conceentration		
	Yes	**No**		**Yes**	**No**
Hostile/Angry Mood			Overacting		
Indecisive			Immature		
Bizarre Behaviors			Other Social Concerns		

Legal History

Have you ever been a victim of a crime? [ ] No [ ] Yes If yes, please explain. _____

Have you ever been convicted of a felony? [ ] No [ ] Yes If yes, please explain? _____

Do you currently have any need of Legal Assistance? [ ] No [ ] Yes If yes, please explain. _____

Please check all that apply for client:

[ ] no legal problems [ ] now on parole/probation [ ] arrest(s) not substance-related [ ] arrest(s) substance-related

[ ] court ordered this treatment [ ] jail/prison _____ time(s) total time served: _____

describe last legal difficulty: _____

Socio Economic History

Living situation:

[ ] adequate housing

[ ] inadequate housing, why?_____

Financial situation:

[ ] no current financial problems

[ ] large indebtedness

[ ] poverty or below-poverty income

[ ] impulsive spending

[ ] relationship conflicts over finances

Military history:

Branch in military: _____

Honorable discharge: Yes [ ] No [ ]

Social support system:

[ ] close relationship with family/friends

[ ] few friends

[ ] substance-use-based friends

[ ] no friends

[ ] distant from family of origin

Church/spiritual/recreational history

Y N

[ ] [ ] Do you attend a church/religious group? If yes, where? _____

[ ] [ ] Are you active in your church/religious group?

Describe your relationship with God/Higher Power: _____

[ ] [ ] Currently active in community/recreational activities?

[ ] [ ] Formerly active in community/recreational activities?

[ ] [ ] Currently engage in hobbies? _____

Misc. _____