

*Counseling Associates for Well-Being*

**Client Information**

Please complete the following questions to the best of your ability.  
They are intended to assist us in providing the most informed care.

**Client Name** \_\_\_\_\_

**Family Information**

Spouse/Partner's name: \_\_\_\_\_ If married, for how long? \_\_\_\_\_

If divorced/separated, for how long? \_\_\_\_\_ Number of marriages: \_\_\_\_\_

What was your age when you first married? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Please list your children's names and ages: \_\_\_\_\_

\_\_\_\_\_

What are your parents' names? \_\_\_\_\_

Parents' marital status? \_\_\_\_\_ If divorced, when? \_\_\_\_\_

What are their ages if living? Mother \_\_\_\_\_ Father \_\_\_\_\_

What was their age at death if deceased? Mother \_\_\_\_\_ Father \_\_\_\_\_

Father's occupation \_\_\_\_\_ Mother's occupation \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_

Please list their names and ages: \_\_\_\_\_

\_\_\_\_\_

Do any blood relatives of yours have any mental health or substance abuse problems? \_\_\_\_\_

Please describe: \_\_\_\_\_

\_\_\_\_\_

**Health Information**

Please provide the name, address and, phone number of your Primary Care Physician (if you have one):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

Please list any medical problems or conditions for which you are currently being treated: \_\_\_\_\_

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Please list any medications which you are currently taking, including any herbal or over the counter medicines: \_\_\_\_\_

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Please list any medications you have taken in the past that were prescribed to alleviate mental health symptoms:

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Have you previously received any counseling, psychotherapy or psychiatric care? \_\_\_\_\_

Please describe (when, what kind, by whom): \_\_\_\_\_

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### **Personal Information**

Name three words to describe yourself: \_\_\_\_\_

Name three words to describe your Father: \_\_\_\_\_

Name three words to describe your Mother: \_\_\_\_\_

Name three words to describe your family of origin: \_\_\_\_\_

Have you ever been physically, emotionally, or sexually abused by anyone? Please briefly describe as much as you are comfortable: \_\_\_\_\_

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Please describe any legal issues (for example custody, probation for DUI, assault etc.) you are currently or have previously been involved in: \_\_\_\_\_

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Please describe your usage of alcohol and/or drugs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you consider yourself to have a healthy relationship with food? \_\_\_\_\_

describe: \_\_\_\_\_

\_\_\_\_\_

Please place a check mark by any of the following symptoms that you have been experiencing:

_____ persistent sadness	_____ irritability	_____ anger
_____ insomnia/sleep problems	_____ change in appetite	_____ increased guilt
_____ thoughts about death	_____ anxiety	_____ nervousness
_____ shortness of breath	_____ headaches	_____ intrusive thoughts
_____ compulsive behaviors	_____ hearing voices or noises	_____ seeing images
_____ restlessness	_____ poor concentration	_____ worrying
_____ loss of interest in things	_____ inability to experience pleasure	
_____ change in energy level	_____ impulsive behavior	_____ recklessness
_____ memory problems	_____ sexual problems	_____ physical pain
_____ numbness or tingling	_____ rapid heart beat	_____ sweating
_____ mood swings	_____ other (describe): _____	

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THIS SECTION FOR OFFICE USE ONLY  
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DSMIV DX:

Axis I: \_\_\_\_\_

AxisII: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

NOTES: \_\_\_\_\_