

**CLINICAL
HISTORY
REPORT**

DEMOGRAPHICS **Date:** _____

Client Name: _____ Client Number: _____

Client Address: _____

Parent(s)/Guardian(s) Name(s): _____

Telephone Number(s): _____ Okay to leave a message? _____

Home#: _____ Yes No Date of Birth: ____/____/____

Work#: _____ Yes No Age: _____

Cell #: _____ Yes No Gender: _____

PRESENTING PROBLEMS **Duration (Months):** _____

1. _____

2. _____

3. _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom 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 for day-to-day functioning **Severe** = Profound impact on quality of life

	None	Mild	Mod	Sev		None	Mild	Mod	Sev		None	Mild	Mod	Sev
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	related medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GOALS FOR COUNSELING

1. _____

2. _____

3. _____

DEVELOPMENT HISTORY (required information under age 18)

Delayed Development or Long Term effects from events: check normal or check description and describe effect

Prenatal/Perinatal Events:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Physical:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Psychological:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Social:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Intellectual:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Academic/Educational:	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Sexual Abuse History	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Physical Abuse History	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____
Trauma Related History	<input type="checkbox"/> Normal	<input type="checkbox"/> Description	_____

FAMILY HISTORY

FAMILY OF ORIGIN: (check all that apply)

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all	Parents current marital status:	Describe parents:	
				<input type="checkbox"/> married to each other	Father	Mother
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> separated for ___ years	full name _____	_____
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> divorced for ___ years	occupation _____	_____
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> mother remarried ___ times	education _____	_____
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> father remarried ___ times	general health _____	_____
brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> mother involved with someone	Describe childhood family experience:	
sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> father involved with someone	<input type="checkbox"/> outstanding home environment	
other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> mother deceased for ___ years	<input type="checkbox"/> normal home environment	
				Age of client at mother's death ___	<input type="checkbox"/> chaotic home environment	
				<input type="checkbox"/> father deceased for ___ years	<input type="checkbox"/> witnessed physical/verbal/sexual abuse toward others	
				Age of client at father's death ___	<input type="checkbox"/> experienced physical/verbal/sexual abuse from others	

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

Has any family member: (check and describe all that apply)

received outpatient psychotherapy? Who/Why: _____

received inpatient treatment for a psychiatric, emotional or substance use disorder? Who/Why: _____

had a history of alcohol/substance abuse? Who/What: _____

IMMEDIATE FAMILY:

Marital status:	Relationship satisfaction:	List all persons currently living in patient's household:
<input type="checkbox"/> single, never married	<input type="checkbox"/> very satisfied with relationship	Name _____ Age Sex Relationship to Client
<input type="checkbox"/> engaged ___ months	<input type="checkbox"/> satisfied with relationship	_____
<input type="checkbox"/> married for ___ years	<input type="checkbox"/> somewhat satisfied w relationship	_____
<input type="checkbox"/> divorced for ___ years	<input type="checkbox"/> dissatisfied with relationship	_____
<input type="checkbox"/> separated for ___ years	<input type="checkbox"/> very dissatisfied with relationship	_____
<input type="checkbox"/> divorce in process ___ months		_____
<input type="checkbox"/> live-in for ___ years		_____
<input type="checkbox"/> prior marriages (partner)		_____

Intimate relationship:

<input type="checkbox"/> never been in a serious relationship	List children not living in the same household as client: Name/Age/Sex/Frequency of contact
<input type="checkbox"/> not currently in relationship	_____
<input type="checkbox"/> currently in a serious relationship	_____

FAMILY HISTORY (continued)

Describe any past or current significant issues in intimate relationships: _____

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

MEDICAL HISTORY

Describe current physical health: Good Fair Poor Name of Primary care physician: _____

Address/Telephone of Family Physician/PCP: _____

Date last seen: _____ release obtained release refused by client

Current Medications/Dosages: (prescription/over the counter/herbal supplements): _____

Allergies to Medications: _____

Name and Contact Information of Psychiatrist (if applicable): _____

Date last seen: _____ release obtained release refused by client

Serious or long term effects of Illnesses, Surgeries, Injuries, and/or Hospitalizations:

Date _____ Age _____ Reason/Effects _____

Date _____ Age _____ Reason/Effects _____

Date _____ Age _____ Reason/Effects _____

Date _____ Age _____ Reason/Effects _____

Date _____ Age _____ Reason/Effects _____

MENTAL HEALTH HISTORY

Prior outpatient psychotherapy? No Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ release obtained release refused by client

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ release obtained release refused by client

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder? No Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ release obtained release refused by client

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ release obtained release refused by client

Current Treatment? No Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ release obtained release refused by client

SUBSTANCE ASSESSMENT (over age 12)

History of Use:

Alcohol: No Yes Description: Frequency: _____ Amount: _____

Drugs: No Yes Description: Frequency: _____ Amount: _____
Description _____

Current Use:

Alcohol: No Yes Description: Frequency: _____ Amount: _____

Drugs: No Yes Description: Frequency: _____ Amount: _____
Description _____

Alcohol/Drug Treatment:

Inpatient: No Yes When/Where: _____

Outpatient: No Yes When/Where: _____

SOCIO-ECONOMIC HISTORY

Current Supportive Relationships: check and describe all that apply

Siblings: _____

Parents: _____

Friendships: _____

Sexual Orientation: heterosexual homosexual bisexual

Cultural/Spiritual/Recreational History:

Cultural identity (e.g. ethnicity, religion): _____

Any cultural or religious issues that contribute to current problems: _____

Currently active in community/church/recreational activities? No Yes Description: _____

Formerly active in community/church/recreational activities? No Yes Description: _____

Currently engaged in hobbies? No Yes Description: _____

Importance of Faith in Counseling: _____

- | | | | | |
|-----------------------------|--|---|--|-----------------------------------|
| Living Situation: | <input type="checkbox"/> housing adequate | <input type="checkbox"/> housing overcrowded | <input type="checkbox"/> dependent on others for housing | <input type="checkbox"/> homeless |
| | <input type="checkbox"/> housing dangerous/deteriorating | <input type="checkbox"/> living companions dysfunctional | | |
| Employment: | <input type="checkbox"/> employed and satisfied | <input type="checkbox"/> employed but dissatisfied | <input type="checkbox"/> unemployed | |
| | <input type="checkbox"/> coworker conflicts | <input type="checkbox"/> supervisor conflicts | <input type="checkbox"/> disabled | |
| | <input type="checkbox"/> student | <input type="checkbox"/> unstable work history | | |
| Education: | <input type="checkbox"/> grades 1-8 | <input type="checkbox"/> some college | <input type="checkbox"/> vocational or tech degree | |
| | <input type="checkbox"/> grades 9 - 12 | <input type="checkbox"/> college graduate | | |
| | <input type="checkbox"/> high school graduate | <input type="checkbox"/> post graduate degree | | |
| Financial Situation: | <input type="checkbox"/> no current financial problems | <input type="checkbox"/> impulsive spending | <input type="checkbox"/> relationship conflicts over finances | |
| | <input type="checkbox"/> large indebtedness | <input type="checkbox"/> poverty or below poverty income | | |
| Military History: | <input type="checkbox"/> never in military | <input type="checkbox"/> served in military - no incident | <input type="checkbox"/> served in military - with incident, describe | _____ |
| Legal History: | <input type="checkbox"/> no legal problems | <input type="checkbox"/> now on probation/parole | <input type="checkbox"/> jail/prison ____ time(s), total time served _____ | |
| | <input type="checkbox"/> arrest(s) not substance related | <input type="checkbox"/> arrest(s) substance related | <input type="checkbox"/> description of last legal difficulty | _____ |
| | <input type="checkbox"/> court ordered this treatment | | | |