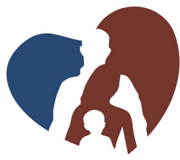

INDIVIDUAL CONCERNS & HISTORY

NAME ____ DATE _____________________

Circle the following terms, which pertain to you or any of your family members. Indicate concerns for yourself with a "S" and concerns for family members with an "F".

Nervousness	Health Problems	Marital Problems	Drug Usage
Shyness	Stomach Problems	Divorce	Alcohol Usage
Anger	Bowel Problems	Separation	Financial Problems
Loneliness	Depression	Affair	Problems w/Friends
Frustration	Headaches	Problems w/ ex-spouse	Can't Have Fun
Temper	Memory Loss	Stress	Tiredness
Self-Control	Sleeping Problems	Grief	Children
Insecurity	Nightmares	Parenting Problems	Career Choices
Fears	No Ambition	Relationship Problems	Problems w/Parents
Panic Attacks	Eating Problems	Legal Problems	Chronic Pain
Isolation	Suicidal Thoughts	Work Problems	School Problems
Can't Concentrate	Lack of Energy	Difficulties in Decision-making	

List any medical problems you have:
____
____
____

If you have noticed any recent changes in the following areas, please select all that apply.

vision hearing coordination balance strength speech memory thinking

energy sleeping eating elimination menstrual cycle sexual activity

List all medication you are taking:
____
____
____
____

Have you ever been hospitalized for mental or nervous problems? **No** **Yes**
If yes, when and where
____

Have you ever attempted suicide? **No** **Yes**

If yes, where and when

____

____

_ Are you suicidal now? **No** **Yes**

How often do you drink alcohol? _________________

Have you ever been arrested for driving under the influence (DUI)? **No** **Yes**
If yes, how many times
____

Do you use drugs? **No** **Yes**
If yes, what drugs do you use and how often?

____

____

Have you ever been arrested? **No** **Yes**
If yes, how many times and for what?

____

____

Are you currently involved or do you expect to be involved in any court related matters? **No** **Yes**

If yes, please describe

____

____

____

____

Have your ever been physically, sexually, emotionally abused (Circle to indicate which ones)?

____Yes _____No If yes, briefly describe: ____

____

____

What is going on in your life, your marriage or family that brings you to counseling?
____

____

____

____

What important things about you, your marriage or family would it be helpful for your therapist to know/(i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

____

____

____

Would you like spirituality included in your counseling process? **No** **Yes**

____

____

____

List any other counseling you or a member of your family are receiving or have received:

____

____

____

What other things are stressful in your life right now?

____

____

Client Signature ____ Date ___________________

FOR THERAPIST USE:

____

____

____

____

____

____

Therapist Signature:

____ Date: ____________________