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Clinical History Inventory

Form Instructions: This form is designed to give your counselor necessary information for providing competent clinical care. Please complete this form in its entirety and bring it to your first session.

IDENTIFICATION DATA

Date: _____

Client Name: _____ (preferred name)_____

Address: _____

Parent/Gaurdian Name(for minor clients) _____

Telephone Number(s) Okay to leave message?

Primary: _____ ❑ Yes ❑ No Date of Birth: ____/_____/_____

Secondary: _____ ❑ Yes ❑ No Age: _____

Work: _____ ❑ Yes ❑ No Sex: Male / Female

REASONS FOR SEEKING COUNSELING — Duration (months)

1. _____ _____
2. _____ _____
3. _____ _____

GOALS FOR COUNSELING

1. _____
2. _____
3. _____

PERSONAL STRENGTHS

List two strengths you have (skills, relationships, beliefs, etc.)

1. _____
2. _____

Please indicate how passionate you are to find solutions to the challenges you are facing.

❑ Extremely motivated ❑ Motivated ❑ Indifferent ❑ Really don't care to change

How confident are you that change and solutions are possible?

❑ Very confident ❑ Hopeful, but stuck ❑ Doubtful ❑ No hope, ready to give up

OBSTACLES TO COUNSELING

What might you do to sabotage the counseling process?

1. _____
2. _____
3. _____

Client Id #_____

Attempts to Change

Please describe ways that you have attempted to resolve the challenges that inspired you to seek counseling.

_____

_____

DEVELOPMENTAL HISTORY

Please note any delayed developmental or long term effects from any event:

Prenatal/Birth _____

Physical _____

Psychological _____

Social _____

Intellectual _____

Academic _____

Physical ,Sexual or Emotional Abuse _____

Trauma _____

MEDICAL HISTORY

Rate your physical health: ❑ Excellent ❑ Good ❑ Average ❑ Declining

If declining, please explain

_____

_____

Are you under the care of a physician? ❑ Yes ❑ No If yes,

Physician:_____ Phone:_____

Address: _____

Date of last medical exam:_____

Recent weight changes: ❑ Lost _____ ❑ Gained _____

Are you pregnant ❑ Yes ❑ No ❑ N/A Any food or drug allergies ❑ Yes ❑ No

List all significant present or past illnesses, injuries or handicaps:

_____

_____

Are you presently taking prescribed or OTC medication? ❑ Yes ❑ No If yes,

Please list all medications:

Medication	Purpose	Dosage/day	Date first prescribed

_____

_____

_____

_____

_____

_____

Client #_____

MENTAL HEALTH HISTORY

Have you ever ever been diagnosed with a mental health disorder? ❑ Yes ❑ No ❑ Not sure

If yes: What was the diagnosis? _____

Name of diagnosing counselor/therapist/doctor: _____

Please list any previous mental health services or counseling you received

1. _____Year_____
2. _____Year_____
3. _____Year_____

Was previous mental health treatment effective? ❑ Yes ❑ No

List factors what were helpful or unhelpful during previous treatment.

1. _____
2. _____
3. _____

Are you feeling hopeless or that life is not worth living? ❑ Yes ❑ No

Do you have a sense of hope and purpose in life? ❑ Yes ❑ No

Are you having thoughts of harming yourself or others? ❑ Yes ❑ No If yes, please explain.

_____

_____

Have you ever attempted suicide? ❑ Yes ❑ No

Do you have access to weapons/firearms? ❑ Yes ❑ No

Sexual Concerns

❑ Addiction ❑ Affairs ❑ Sexual Performance ❑ Sexual Relationship Difficulties ❑ Sexual Identity Concerns

Please briefly explain:

_____

_____

FAMILY HISTORY

If you were raised by anyone other than your own biological parents, briefly explain your childhood living arrangements:_____

_____

Answer this section describing your own family:

Still living? Father: ❑ Yes ❑ No Mother: ❑ Yes ❑ No

Occupation: Father _____ Mother _____

Rate your parents' relationship: ❑ Unhappy ❑ Indifferent ❑ Happy ❑ Very Happy

As a child, did you feel close to your ❑ Father ❑ Mother:

Rate childhood: ❑ Happy ❑ Traumatic ❑ Lonely ❑ Unhappy ❑ Other_____

FAMILY HISTORY Cont...

Are your parents still married? ❑ Yes ❑ No

If "No", what was your age at the time of divorce/separation? _____

How many brothers/sisters do you have? _____

Your Birth order _____ (examples: "oldest", "3rd out of 5", etc.)

Describe your relationship with your parents/step-parents _____

_____

Describe your relationship with your siblings:

_____

_____

Is there a family history of emotional/mental health difficulties? ❑ Yes ❑ No

If yes please describe: _____

_____

Has anyone in your family ever attempted or committed suicide? ❑ Yes ❑ No

If yes please explain:

_____

_____

Please note any family background information that you believe would be helpful in the counseling process.

_____

_____

_____

SUBSTANCE ASSESSMENT

History of use:

Past alcohol use ❑ Yes ❑ No How often? _____ Amount _____

Past other substance use ❑Yes ❑ No How often? _____ Amount _____

List other substances used: _____

_____

Current use:

Alcohol ❑ Yes ❑ No How often? _____ Amount _____

Other substance ❑Yes ❑ No How often? _____ Amount _____

List other substances being used: _____

_____

Alcohol/Drug Treatment:

Inpatient: ❑ Yes ❑ No When/Where: _____

Outpatient ❑ Yes ❑ No When/Where: _____

MARRIAGE INFORMATION (If never married, omit this section.)

If currently divorced, for how long? _____

How many times have you been married, including current marriage? _____

Do you desire to have your spouse join the counseling sessions? ❑ Yes ❑ No

Is your spouse willing to join you in counseling? ❑ Yes ❑ No

Current spouse's Name: _____ Age_____

Are you currently living with spouse? ❑ Yes ❑ No

Is there any history of violence in the relationship? ❑ Yes ❑ No If yes please explain:

_____

_____

Have either of you ever filed for legal separation or divorce? ❑ Yes ❑ No

The number of years married _____ Ages when married: You ____ Spouse ____

How long did you date your spouse _____ How long was the engagement? _____

Give brief information about any previous marriages: _____

_____

_____

Children

Do you have any children? ❑ Yes ❑ No ❑ Not sure If yes, how many? _____

Are your children from your current marriage or relationship? ❑ Yes ❑ No How many? _____

How many from former marriage/relationship? _____

Please list children's names and ages for those under age 18:

_____

_____

Are you the custodial parent for the above minors? ❑ Yes ❑ No if no, explain_____

_____

_____

Faith & Spirituality

Do you identify as: ❑ Christian ❑ Muslim ❑ atheist/agnostic ❑ other _____

Do wish to incorporate your faith in the counseling process? ❑ Yes ❑ No ❑ Not sure

On average, how often do you attend a religious service each month? _____

Are there particular religiou/spiritual activities that are part of your life (prayer, Scripture, meditation)? ❑ Yes ❑ No

If yes please explain:

_____

_____

SOCIAL-ECONOMIC HISTORY

Please indicate the nature of the following relationships.

:

Supportive?	Yes	No	Hostile		Yes	No	Hostile
Mom	O	O	O	Pastor/Preist	O	O	O
Dad	O	O	O	Friend	O	O	O
Siblings	O	O	O	Co-worker	O	O	O
Grandparent	O	O	O	Boss	O	O	O
Spouse	O	O	O	Other_____	O	O	O

Please indicate sexual orientation. ❑ Heterosexual ❑ LGBT ❑ Not sure

Are there important cultural or religious traditions and expectations that are part of your current challenges? If so, explain:

_____

_____

Please list any support groups or friendships that are important to you. _____

_____

Do you have adequate housing ❑ Yes ❑ No Explain _____

Employment status? ❑ employed ❑ unemployed ❑ disablity ❑ other _____

Are you statisfied with your current employment? _____

Do you make adequate income to meet your financial obligations? ? ❑ Yes ❑ No

Are you a veteran or current member of the military? ❑ Yes ❑ No Served in combat operations? ❑ Yes ❑ No

List hobbies/free time activities you enjoy? _____

_____

EDUCATION (circle last year completed)

Grade school: 1 2 3 4 5 6 7 8 High school: 9 10 11 12 College: 1 2 3 4 5 6+

Other formal training: (list type & years) _____

Please describe any additional information that you believe will be helpful in addressing the challenged that inspired to you seek counseling.

_____

_____

_____

_____