

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)

- | 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. _____

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

MENTAL HEALTH HISTORY

Have you 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 If yes, please explain

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pastor/Preist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Siblings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Co-worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grandparent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Boss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 disability other _____

Are you satisfied 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.
