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Pathways Counseling

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Client Information

Name: _____ Today's Date: _____

Gender: _____ Date of Birth: _____ Age: _____

Home Address: _____

City/State: _____ Zip: _____

Email: _____

Cell Phone: _____ ❑ Check if OK to leave a message

Other Phone: _____ ❑ Check if OK to leave a message

Relationship Status: ❑ Single ❑ Partner, not married ❑ Married ❑ Separated
❑ Divorced ❑ Widowed Number of previous marriages: _____

How long with current partner? _____ Living together? ❑ Yes ❑ No How long? _____

Children (names and ages): _____

Who lives in your household? _____

_____

Highest Level of Education: _____

Occupation: _____

Employer: _____

Ethnic/Cultural Background (optional): _____

Spiritual Practice/Religious Affiliation (optional): _____

Person I can contact in case of emergency:

_____

Name **Relationship** **Phone**

How did you find me? _____

Your answers below will help me to understand you better, and will be kept confidential. Feel free to write on the back or attach additional pages, if you wish to add more information.

FAMILY HISTORY

In a few words, describe what your relationship has been like with your:

Mother: _____

_____

Father: _____

_____

Brothers and sisters (include names and ages): _____

_____

_____

Other significant family members: _____

_____

Before you were 18, did you experience any of the following?:

- ❑ Parents divorced (Your age _____)
- ❑ Adopted (At what age? _____)
- ❑ Lived with step-parent or step-siblings
- ❑ Other _____
- ❑ Raised by someone other than parent (Who? _____)

Have you experienced the death of someone close to you? Please give the name and relationship of the person(s), cause of death, and when they died (or your age at the time):

_____

_____

Did either of your parents abuse alcohol or other drugs? _____

_____

Were the adults in your household abusive or disrespectful to each other?_____

_____

Were you verbally, emotionally, sexually or physically abused? _____

_____

Do any of your current or extended family members have a history of mental illness (depression, anxiety, attention deficit disorder, addictions, etc.)? _____

_____

Has anyone close to you committed suicide or attempted to commit suicide? _____

_____

Is there anything that troubles you about your childhood (family, school, social, etc.)?_____

_____

HEALTH HISTORY

Current physical health concerns (including chronic conditions): _____

_____

Current prescribed medications you are taking and condition or symptoms addressed: _____

_____

Previous medical hospitalizations, serious illnesses or injuries, seizures, head injuries or numbness:

_____

_____

Previous experiences with counseling (include approximate dates, length of time, and reasons): ____

_____

_____

Do you have any previous mental health diagnoses? _____

_____

Have you ever been hospitalized for mental illness? _____

Have you ever attempted suicide or had serious thoughts of suicide? If yes, when and why?

_____

_____

How often do you use alcohol or other drugs? (*Respond with your average, typical use*)

❑ Daily ❑ 1 to 2 times per week ❑ Less than once per month
❑ 2 to 5 times per week ❑ 1 to 2 times per month ❑ Never

Type(s) of alcohol or drugs consumed: _____

Amount(s) consumed per occasion: _____

_____

Has your alcohol or drug use caused problems in your life? ❑ Past ❑ Present ❑ None

Please explain: _____

_____

Have you struggled with any other behaviors that felt compulsive or difficult to control such as overeating, an eating disorder, pornography use, gambling, spending money, Internet use/gaming, excessive sexual activity, etc? Please describe briefly and indicate whether it is past or present.

_____

_____

Is there anything in your sexual history that disturbs you? _____

_____

SELF CARE

What are the major stresses in your life?_____

_____

What do you do to relax or relieve stress? _____

_____

Who can you turn to for emotional support? _____

_____

How much do you typically sleep? Do you have any sleep problems? _____

_____

THERAPY GOALS

What brings you to therapy at this time? (Please describe the issues and concerns for which you are seeking counseling.) _____

_____

_____

_____

_____

_____

How do you hope your life will be different after counseling? _____

_____

_____

Is there anything else you would like me to know about you?_____

_____

_____

_____