Date___/___/___

Name: _____ DOB: ___/___/_____Age_____

Gender ❑ F ❑ M ❑ Other_____

Address: _____TX_____

Street City Zip

Phone: (Cell) _____ (Home) _____ is it ok to leave messages? ❑ Yes ❑ No

Email: _____ Highest Education Attained:_____

Occupation: _____ Place of Employment: _____

Relationship Status: _____ Partner/ Significant Other's Name _____

age _____ occupation_____

Persons Living with You

Relationship	Name	Gender	Age	Quality of Relationship
_____	_____.	M / F	_____	Poor/ Average / Good
_____	_____.	M / F	_____	Poor/ Average / Good
_____	_____.	M / F	_____	Poor/ Average / Good
_____	_____.	M / F	_____	Poor/ Average / Good
_____	_____.	M / F	_____	Poor/ Average / Good

Social Relationships

Check how you generally get along with other people: (check all that apply)

❑ Affectionate ❑ Aggressive ❑ Avoidant ❑ Fight/argue often ❑ Outgoing ❑ Follower ❑ Friendly ❑ Leader ❑ Shy/withdrawn ❑ Submissive

Other (specify): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong/identify? _____

Spiritual/Religious

Any religious affiliations/beliefs ❑ Yes ❑ No _____ Practicing: ❑ Yes ❑ No

How important are spiritual matters to you? ❑ Not ❑ Somewhat ❑ Moderately ❑ Very

Comments_____

Legal

Are you currently or have you ever been involved any **active cases** (traffic, civil, criminal)?

❑ Yes ❑ No

Are you presently on probation or parole? ❑ Yes ❑ No

_____

_____

_____

Military

Military experience? ❑ Yes ❑ No; Combat experience? ❑ Yes ❑ No

Comments: _____

_____

_____

_____

_____

Medical

List any current health problems/concerns:

_____

_____

_____

_____

Current medications/ Dose Purpose Side effects

_____

_____

_____

_____

_____

_____

Psychosocial History

Please check behaviors and symptoms which apply to you in the last four to six weeks.

❑ Aggression
❑ Alcohol dependence
❑ Anger
❑ Antisocial behavior
❑ Anxiety
❑ Avoiding people
❑ Chest Pain
❑ Porn addiction
❑ Depression
❑ Disorientation
❑ Distractibility
❑ Dizziness
❑ Drug dependence
❑ Panic attacks
❑ Elevated mood
❑ Fatigue
❑ Gambling
❑ Hallucinations
❑ Heart palpitations
❑ Compulsive Video Gaming
❑ Hopelessness
❑ Impulsivity
❑ Irritability
❑ Judgment errors
❑ Loneliness
❑ Memory impairment
❑ Mood shifts

❑ Phobias/fears
❑ Recurring thoughts
❑ Sexual addiction
❑ Sexual difficulties
❑ Eating disorder
❑ Sick often
❑ Sleeping problems
❑ Speech problems
❑ Suicidal thoughts
❑ Disorganized thoughts
❑ Trembling
❑ Withdrawing
❑ Worrying

Do you ever drink alcohol? ❑ Yes ❑ No; If yes, what and how often? _____

_____

Use drugs? ❑ Yes ❑ No; If yes, what and how often? _____

If you or anyone in your household has a history with any of the following, please select all that apply.

❑ Physical Abuse Family member / age: _____

❑ Sexual Abuse

❑ Emotional Abuse

❑ Neglect

❑ Drug Abuse

❑ Alcoholism

❑ Domestic violence

❑ Psychiatric difficulties

❑ Criminal difficulties

❑ Other: _____

❑ Other (specify): _____

Comments:_____

_____

Suicide

Have you ever considered suicide? ❑ Yes ❑ No

Attempted? ❑ Yes ❑ No

Have you considered suicide in the last 60 days? ❑ Yes ❑ No; Attempted? ❑ Yes ❑ No

Are you currently considering suicide? ❑ Yes ❑ No

Have you ever received counseling/psychiatric treatment? ❑ Yes ❑ No

Comments:_____

_____

_____

_____

GOALS

What are your goals for therapy?

_____

_____

_____

_____

Additional Information

Any other information you think your counselor should know?

_____

_____

_____

_____

_____

Signature_____ Date_____