COUNSELING BACKGROUND FORM

Name: _____ DOB: _____
Address: _____
Phone: _____ May I leave a message? Y / N
Is it OK to email you? If so, email address: _____
Emergency Contact & phone number: _____

Relationship Status: (check all that apply)
☐Married ☐Living Together ☐Divorced
☐Separated ☐Living apart ☐Dating

Do you have children? If so, please list their names and ages:

_____

OCCUPATIONAL INFORMATION
Are you currently employed? ( ) no ( ) yes
If yes, who is your currently employer/position? _____
If yes, are you happy with your current position? _____
Please list any work-related stressors, if any _____
_____

SOCIAL/FAMILIAL INFORMATION
Briefly describe any social support you have (someone you can turn to when distressed). _____
_____

Briefly describe your relationship with your family/caretaker of origin. _____
_____

TREATMENT HISTORY
Are you currently receiving **psychiatric services, professional counseling, or psychotherapy** elsewhere?
( ) yes ( ) no If yes, please list: _____

Have you had previous counseling/psychotherapy? ( ) no ( ) yes, with (previous therapist's name)
_____

If yes, what did you seek counseling for? _____
Were you satisfied with previous counseling experience(s)? _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no

If yes, please list: _____
Prescribed by: _____

Do you currently have a primary physician? ( ) yes ( ) no
If yes, who is it? _____

Are you currently seeing more than one **medical** health specialist? ( ) yes ( ) no
If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____
_____

Are you currently on medication to manage a physical health concern? If yes, please list:
_____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no
If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How often do you exercise? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes
If yes, check where applicable:

( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

How often do you use alcohol? _____
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____
_____

How often do you engage recreational drug use? What type? _____
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco/nicotine products? ( ) yes ( ) no
What type? _____

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

In the last year, have you experienced any significant life changes or stressors?
If yes, please explain: _____
_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

TRAUMA HISTORY

As a child, did you ever experience sexual, physical, or emotional/verbal abuse or neglect by a caregiver or someone older than you? (please circle all that apply). Who was the offender? _____
_____

As a child, did you ever experience any trauma or situation that had a significant emotional or otherwise impact? (e.g., loss/death, bullying, parental drug use, violence in/out of home, divorce of parents, accident, illness)? Please describe. _____
_____
_____

As an adult, did you ever experience any trauma or situation that had a significant emotional or otherwise impact? (e.g., partner violence, assault, loss/death, illness, accident, layoff, breakup)? Please describe. _____
_____

CULTURAL/RELIGIOUS/SPIRITUAL INFORMATION

What is your cultural background? _____
What languages do you speak? _____
To what extent do cultural issues impact your identity or relate to your current wellbeing?
_____

Do you consider yourself to be religious? ( ) no ( ) yes
If yes, what is your faith tradition/religion? _____
If yes, is religion a source of support for you? _____
Is religion a source of trauma and/or discomfort? _____
Do you consider yourself to be spiritual? ( ) no ( ) yes
Do you want to incorporate spiritual/religious elements into counseling? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

CURRENT REASON FOR SEEKING COUNSELING

What brings you to counseling? _____
_____
_____

Why now? _____
_____

How long has this been going on? _____
_____

What have you done in the past to address it? _____
_____

What do you consider to be your strengths? _____
_____
_____

What do you like most about yourself? _____
_____

What are effective coping strategies that you have learned? _____
_____
_____

Thank you for completing this form!