River Bend Counseling

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## CONFIDENTIAL HISTORY INFORMATION

CLIENT NAME: _____

What has led you to seek counseling or evaluation at this time:

_____

When did these concerns or struggles develop?

_____

Have you ever attempted suicide or made any self-harm attempts: YES NO If yes, how long ago was the last attempt: _____

Do you have current thoughts of ending your life or harming yourself: YES NO If yes, what is your plan:

_____

Do you have current thoughts of harming anyone else: YES NO If yes, what is your plan:

_____

Are you currently experiencing overwhelming sadness, grief, or depression? YES, NO If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? YES, NO If yes, when did you begin experiencing this? _____

What significant life changes or stressful events have you experienced recently:

_____

Support System: Who can you count on for support: (please circle all that apply)

Parents Spouse Significant Other Self-Help Group Employer Church Therapist
Neighbor Extended Family Close Friend Pastor Siblings Co-Worker Medical Doctor
Other: _____

Symptoms, Specific Concern or Problem Areas: (Please circle any that are currently troubling you)

Abortion Addictions Adoption Alcohol Use Ambition Anger/Temper Anxiety Apathy Appetite/Weight Bitterness/Resentment
Burnout/Stress Change in Life Child Abuse Child/Parenting/Discipline Child/Rebellion Child/Schooling Communication
Concentration Confusion Crisis Death Decisions Depression Divorce Dreams Drug Use Eating Disorder Education
Emotional Abuse Employment/Job Problems Energy Envy/Jealousy Family Issues Father Issues Fear Finances/Debt Forgiveness
Friends Frustration Grief Guilt Health/Medical Inferiority Infidelity In-laws Legal Matters Loneliness Loss of
Control Loss of Trust Low Energy Marriage Medication/Drug Issues Memories Mid-life Mother Issues Nervousness
Nightmares Panic Attacks Physical abuse Poor Concentration Poor Memory Pornography Rejection Relaxation
Religion/Spiritual Issues Self-Control Self-Esteem Separation Sexual Abuse/Rape Sexual Addiction Sexual Issues Shyness
Single parent Singleness Sleep Spouse Abuse Stomach Problems Stress Substance Abuse Suicidal Thoughts Thoughts
Tiredness Unemployment Unhappiness Violence/Rage Withdrawal Work Worry

## PREVIOUS COUNSELING OR MENTAL HEALTH TREATMENT

Have you ever been in counseling before? YES NO

Have you ever been hospitalized for a mental health or addiction reason? YES NO

If yes to either of the above questions, please describe it below. Start with most recent time first.

A. When was the counseling or hospitalization?

_____

Where did you go? _____
Name:_____

Explain what happened:_____
What was helpful to you:_____

What are the current prescription medications you are taking? _____

MEDICATION DOSE_____
PRESCRIBING PHYSICIAN _____

In the past, which psychiatric medications were prescribed for you? _____

MEDICATION DOSE APPROXIMATE DATE _____
_____ _____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for you? YES NO

If yes, please describe _____ date:_____

RELATIONSHIPS: Are you currently in a romantic relationship YES NO

If yes, for how long? ___ On a scale of 1-10, (1 = needs work, 10 = outstanding), how would you rate your relationship? _____

Your current Marital Status (please circle):

NEVER MARRIED DOMESTIC PARTNERSHIP MARRIED SEPARATED DIVORCED WIDOWED

Please list any children and their ages:

_____
_____
_____
_____

## FAMILY OF ORIGIN

Parents' marital status:

NEVER MARRIED MARRIED SINGLE DIVORCED WIDOWED SEPARATED
OTHER:_____

How would you describe their relationship? EXCELLENT GOOD FAIR POOR N/A

Mother's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____

Your age at the time of her death _____

Describe your relationship with your Mother: EXCELLENT GOOD FAIR POOR N/A

Father's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____

Your age at the time of his death _____

Describe your relationship with your Father: EXCELLENT GOOD FAIR POOR N/A

Do you have stepparents? YES NO

Describe your relationship with your Stepparents: EXCELLENT GOOD FAIR POOR N/A

How would you describe your childhood: TRAUMATIC PAINFUL UNEVENTFUL LOVING JOYFUL OTHER
Please explain:

_____

_____

## GENERAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please circle all currently difficulties that you are currently experiencing:

Accidents Anorexia/bulimia Arthritis Back injury/pain Blackouts Blood pressure (high or low) Blood sugar (high or low)
Bowel Problems Burning or itchy skin Cancers Chest pains Constipation Chronic pain Dementia Diabetes
Diarrhea Dizziness Don't like to be touched Dry mouth Eating patterns Excessive sweating Fainting spells Falling
Fatigue Flushes Hair loss Headaches Head injury/trauma Hearing problems Heart disease
Hormone changes Hospitalizations Hypertension Indigestion Infections Influenza Muscle spasms
Nausea Overeating Palpitations Pneumonia Poor appetite Pregnancy Rapid heart rate Renal problems
Respiratory problems Sexual problems Skin problems Sleep problems Stomach problems Stroke Surgeries Tension
Thyroid Tics Tingling Transplants Tremors Twitches Unable to relax Visual disturbances Vomiting
Watery eyes Weight

Please list any other major health problems or events you experienced:

_____

_____

Rate your current sleeping habits? (please circle) POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

Types of exercise: _____

Please circle all that you have tried or are currently using. Circle (P) if it was in the past. Circle (C) for current.

C Acid – LSD P C Alcohol P C Ambien P C Amphetamines P C Anti-depressant P C Anti-Anxiety P

C Barbiturate P C Benzodiazepines P C Caffeine P C Codeine P C Coffee P C Coke P C Cocaine P

C Crack P C Dextromethorphan P C Diuretics P C Energy drugs P C Fentanyl P C Flunitrazepam P

C GHB P C Hashish P C Heroin P C Hydrocodone P C Inhalants P C Ketamine P C Marijuana P

C Meperidine P C Mescaline P C Methadone P C Methamphetamine P C Methylphenidate P C Milk P

C Morphine P C Mushrooms P C MDMA P C Pain Relievers P C PCP P C Propoxyphene P

C Psilocybin P C Opiates P C Oxycodone P C Oxymorphone P C Salvia divinorum P C Soda pop P

C Sleep mediation P C Spice P C Sport's drinks P C Steroids P C Stimulants P C Tea P C Tobacco P C Water P

Have you ever felt that you should cut down on your alcohol or other drug use (including prescription drugs)? YES NO

Has a friend or relative discussed concerns about your use? YES NO

Have you had to take a drink or use a drug the next day to steady your nerves? YES NO

How often do you find that you stay online longer than you intended?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

How often do others in your life complain to you about the amount of time you spend online?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

## CURRENT LIVING ARRANGEMENT / FAMILY SITUATION

Significant individuals or family members currently living with you:

Name Gender Age Relationship to you

_____

_____

_____

_____

_____

_____

Significant individuals or family member currently NOT living with you:

Name Gender Age Relationship to you

_____

_____

_____

_____

_____

_____

## OCCUPATION

Are you currently employed? YES NO FULL TIME PART TIME

If yes, employer and occupation:

_____

_____

How long employed or unemployed? _____

Do you enjoy your work? _____

What are the stressful features about your current work? _____

_____

_____

Your current approximate household income $ _____ per _____

What is your dream job? _____

## LEGAL HISTORY

Have you ever been charged with a crime other than minor traffic violations? YES NO (If yes, please explain):

_____

_____

Have you ever been involved in domestic violence? YES NO (If yes, please explain):

_____

_____

Are you currently involved in a legal matter? YES NO (If yes, please explain):

_____

_____

## EDUCATION HISTORY

What was school like for you?

_____

_____

Highest level achieved? _____

What type of grades did you make? _____

What was your major? _____

## SPIRITUAL AND CULTURAL

Which best describes your spiritual beliefs or worldview:

Agnostic Atheist Christian Baha'i Buddhism Cao Dai Hinduism Islam Jainism Juche Judaism Neo-Paganism Nonreligious Unitarian Universalism Rastafarianism Sikhism Shinto Spiritism Spiritual but unaffiliated Taoism Tenrikyo Zoroastrianism Other:

_____

Growing up, how would you rate your spiritual or religious experiences on a scale of 1-5 (please circle rating):
very harmful 1 2 3 4 5 very helpful

Would you like to discuss God in your counseling sessions? _____

Would you like to pray in your counseling sessions? _____

Please list any concerns, which may have affected you, in regard to spiritual or cultural experience:

_____

_____

_____

_____ _____

*Signature of individual giving this report* *Date*