Therapist:_____ Client Name: _____

SOLUTION-BASED COUNSELING SERVICES, LLC
CLIENT INFORMATION PACKET – ADULT (AGES 18 & OLDER)

PERSONAL HISTORY INFORMATION

What recently happened to cause you to decide to seek help now?:_____

_____

What would you like to achieve in counseling?:_____

_____

SYMPTOMS

Please circle all of the items that you are experiencing.

Anxiety	Panic Attacks	Obsessive or Compulsive Behavior
Depression	Crying Spells	Hopelessness
Relationship Problems	Relationship Breakup	Anger
Loneliness	Emptiness	Loss of Appetite
Sleep Disturbance	Nightmares	Hearing Voices
Feeling Controlled	Feeling Talked About	Visual Hallucinations
Unusual Thoughts	Increased Alcohol Use	Increased Drug Use
Blackout/Memory Loss	Withdrawal Symptoms	Increased Medication Use
Food Binging	Purging	Yelling or Breaking Things
Hitting	Endangering Self	Endangering Others
Gambling	Increased Spending	Sexual Behavior
Cannot Concentrate	Confusion	Mood Swings
Racing Thoughts	Fear of Dying	Job Stress
Decreased Activity	Decreased Self Care	Guilt/Shame
Financial Worries	Sexual Problems	School Problems

Comments/Other Symptoms:_____

_____

How long have you been experiencing these symptoms?:_____

Do you have any thoughts now or recently of wishing you were dead?:_____

Do you have any thoughts now or recently of harming yourself?:_____

Have you ever attempted to commit suicide or seriously harm yourself?: ___Yes ___No When?:_____

Please explain (how/why):_____

Has anyone in your family attempted or committed suicide?: ___Yes ___No Who?:_____

Please explain:_____

Have you ever attempted to kill or seriously harm someone else?: ___Yes ___No Who?:_____

Please explain:_____

Have you ever experienced any of the following?: Physical Abuse ___Yes ___No Sexual Abuse ___Yes ___No

Emotional Abuse ___Yes ___No or Verbal Abuse ___Yes ___No

Please explain:_____

Have you ever received treatment for the abuse: ___Yes ___No If yes, when?:_____

Was it helpful**?:**_____

PREVIOUS TREATMENT

List all of the previous experience you have had with counseling/mental health:

Dates Reason Outcome .

Was your experience helpful?_____

List all mental health/psychiatric hospital or residential treatment centers you have been admitted to:

Dates Reason Location Outcome .

Was your experience helpful?_____

Have you recently, or in the past, ever been prescribed medications to treat a psychiatric condition?: ___Yes ___No

Have any of those medications helped?: ___Yes ___No Please Explain:_____

Is there a history of psychiatric treatment or hospitalizations in your family?: ___Yes ___No

Please explain:_____

Are you involved in any self-help support groups?: ___Yes ___No Which ones:_____

PHYSICAL HEALTH

Please list all medical conditions you have had or currently have and the approximate age of onset:

Condition Age First Occurred Currently Treated Y/N

Are you allergic to any medication?: ___Yes ___No Please list:_____

Do you currently take any medications? ___Yes ___No

Name of Medication Dosage Taking Doctor Who Prescribed it .

Primary Care Physician's Name:_____

Address:_____ City:_____ State:_____

Zip Code:_____ Phone Number:_____

Date of your last physical:_____ Results:_____

Preferred Hospital (in case of emergency):_____

PERSONAL HEALTH INFORMATION

Have you experienced any significant weight changes? ___Yes ___No Explain:_____

_____

Do you exercise regularly?: ___Yes ___No How many days per week:_____

What kind of exercise do you do?:_____

How would you rate your diet?:___Healthy ___Unhealthy ___Mixed Are you concerned about your diet? ___Yes ___No

Please explain:_____

Do you have trouble sleeping?: ___Yes ___No Explain:_____

Family Information: Full Name	**Age**	**Living with you**	**Deceased**
Father:_____			
Stepfather:_____			
Mother:_____			
Stepmother:_____			
Siblings:_____			
_____			
_____			
Spouse/Partner:_____			
Roommate/Other:_____			
Children:_____			
_____			
_____			
_____			

Current Relationship Status:_____ Number of Marriages:_____

Age Married/Together Years Married/Together Reason Ended_____

_____

_____

Are you currently living with a partner: ___Yes ___No Assessment of current relationship: ___ Good ___ Fair ___Poor

Parents marital status:_____Number of Parents Marriages:_____

If parents are divorced, your age at time of divorce:_____

Relationship to parents during childhood: _____ Good _____ Fair _____Poor

Who were you raised by?:_____ Were you adopted?:_____

Which family members are you close to now?:_____

INTERESTS/ACTIVITIES

What do you enjoy doing in your free time?:_____

How do you relate to others?: _____Easily _____Shy _____Loner _____Slow to Warm-up _____Outgoing

Who do you socialize with?: _____Family _____Friends _____Spouse/Partner Other:_____

Have you recently lost interest in activities that you normally enjoyed?: ___Yes ___No

Please explain:_____

Do you feel you spend enough time on your interests and hobbies?: ___Yes ___No

Please explain:_____

ALCOHOL AND DRUG USAGE

Please complete even if you feel your usage is not a problem

About how often do you drink alcohol?:_____

On the days that you drink, about how much do you consume?:_____

About how often do you drink more than you planned to?:_____

Have you ever experienced blackouts when drinking?: ___Yes ___No

If you used to drink, when did you stop?_____ Why?:_____

Please list other drugs used regularly or recreationally (including caffeine, cigarettes, marijuana, illegal drugs, or misused prescription medications):

Name of Drug Amount Used Age First Began Last Used____ .

_____

_____

_____

_____

Have you ever overdosed? ___Yes ___No With what substance?:_____

Explain situation:_____

_____

Has drinking or drug use ever caused you a problem in any of the following areas?:

____Family ____Legal ____Social ____Behavior ____Employment ____Emotional ____Financial ____Medical

Has a friend, loved one, or employer ever told you that you have a drug or alcohol problem?: ___Yes ___No

Has a friend, loved one, or employer ever commented on your usage?: ___Yes ___No

Have any family members had a drug or alcohol problem? ___Yes ___No Who?:_____

LEGAL HISTORY

Have you ever been arrested?: ___Yes ___No Are you currently on probation?: ___Yes ___No

Are you currently on parole?: ___Yes ___No Ending probation/parole date:_____

Are you currently involved in any lawsuits?: ___Yes ___No Explain:_____

Do you have any upcoming court dates?: ___Yes ___No When/For which court?_____

Please list all current and previous arrests/charges:

Arrest Date Charge Convicted Sentence .

_____

_____

_____

FINANCIAL

Do you have any financial problems currently?: ___Yes ___No

Please explain:_____

_____

Do you feel you spend more than you should on a weekly basis?: ___Yes ___No

Please explain:_____

EMPLOYMENT

Occupation Employer Years Employed Reason for Leaving .

Have you ever been fired from a job?: ___Yes ___No How many times?:_____

Reasons:_____

Do you have any problems at your current job?: ___Yes ___No Please explain:_____

Are you satisfied with your level of employment?: ___Yes ___No Please explain:_____

Employment goals:_____

MILITARY SERVICE

Have you ever served in the military?: ___Yes ___No Branch:_____ Years served:_____

Type of discharge (explain if dishonorable):_____

Did you have any combat experience?: ___Yes ___No Location:_____

Are you troubled now by your military experience?: ___Yes ___No If so, explain:_____

Client's Signature Date

Therapist's Signature/Credentials Date

Therapists Comments:_____