ARCADIAN
COUNSELING

Client History and Information

Date: _____
Client Name: _____
Date of Birth: _____
Race/Ethnicity: _____
Religion: _____
Marital Status: ☐Married ☐Never married ☐Separated ☐Divorced ☐Widowed
Living Situation: _____
Address: _____
Home Phone: _____May we leave a message? ☐ Yes ☐ No
Cell/Other Phone: _____ May we leave a message? ☐ Yes ☐ No
Email: _____May we email you? ☐ Yes ☐ No
*NOTE: Email & Text Messaging correspondence are not considered a confidential medium of communication.

If the above patient is a minor complete the following:

Name of Guardian: _____
Address of Guardian: _____
_____

Phone Number of Guardian: _____ May we leave a message? ☐ Yes ☐ No

Who referred you to our office, or how did you learn about our practice?
_____

Emergency Contact Information

In case of an emergency, who should we contact?
Name: _____
Relationship: _____
Address: _____
Phone Number: _____

Presenting Problem

Who is providing the history information? ☐Client ☐Guardian ☐Other

Please describe the current complaint or problem as specifically as you can, including how long you have experienced this problem, or when you first noticed it?
_____
_____
_____
_____
_____

What stressors may have contributed to the current complaint or problem?
_____
_____
_____
_____
_____

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Check all words or phrases that describe what you are experiencing.

☐Substance abuse/dependence/addiction
☐Depression/sad/down feelings
☐High/low energy level
☐Crying spells
☐Angry/irritable
☐Loss of interest in activities/difficulty enjoying things
☐Mood swings
☐Change in weight or appetite
☐Change in sleeping pattern
☐Self-harm/cutting/burning yourself
☐Poor concentration/difficulty focusing
☐Feelings of hopelessness/worthlessness
☐Feelings of shame or guilt
☐Feelings of inadequacy/low self-esteem
☐Withdrawing from people/isolation
☐Anxious/nervous/tense feelings
☐Panic attacks
☐Racing or scrambled thoughts
☐Flashbacks/nightmares
☐Hearing voices/seeing things not there
☐Paranoid thoughts/thoughts that someone is watching you, out to get you or hurt you
☐Thoughts of running away
☐Perfectionism
☐Rituals of counting things, washing hands, checking locks, doors, stove, etc. /overly concerned about germs
☐Binge eating/purging
☐Excessive exercise
☐Job problems
☐Other_____

Add details for any checked items:

_____
_____
_____
_____
_____

History of Presenting Problem

Have you received or participated in previous counseling and/or therapy? ☐Yes ☐No
Describe your previous treatment experience. ☐N/A

_____
_____
_____
_____

Have you had hospital stays for psychological concerns? ☐Yes ☐No
Are you currently experiencing thoughts of harming yourself or someone else? ☐Yes ☐No
Have you in the past experienced thoughts of harming yourself or someone else? ☐Yes ☐No

Medical History

List any current or important past medications, their dose and your response to them.

_____
_____
_____
_____
_____

List any history of serious childhood illnesses.

_____
_____
_____
_____
_____

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List any other health concerns, serious illnesses, head injuries, seizures, conditions, or major operations requiring hospitalization during your lifetime.

_____
_____
_____
_____
_____

List any allergies.

_____
_____
_____

How would you rate your current physical health?
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor
What was the date of your last physical or routine health check-up? _____
Do you have a primary care physician? ☐Yes ☐No
If yes, who is your primary care physician, address and phone number?

_____
_____
_____

Will you give consent to coordinate care with your PCP? ☐Yes ☐No
How many caffeinated drinks do you consume each day/week?

_____

Do you use nicotine in any form? ☐Yes ☐No Include type and amount below.

_____
_____

Do you have a healthy diet? ☐Yes ☐No Give more detail below.

_____
_____

Do you exercise? ☐Yes ☐No Give details below.

_____
_____

Family History

Who were you raised by? ☐Mother ☐Father ☐Step-mother ☐Step-father ☐Other _____
Rate your relationship with:
Mother: ☐Good ☐Fair ☐Poor ☐Close ☐Distant ☐Other _____
Father: ☐Good ☐Fair ☐Poor ☐Close ☐Distant ☐Other _____
Step-parent: ☐Good ☐Fair ☐Poor ☐Close ☐Distant ☐Other _____
Other: _____ ☐Good ☐Fair ☐Poor ☐Close ☐Distant ☐Other _____
List your siblings and describe your relationship (Good, fair, poor, close, distant, etc.) with them?
Name _____ Age _____ Gender _____ Relationship _____
Name _____ Age _____ Gender _____ Relationship _____
Name _____ Age _____ Gender _____ Relationship _____
Name _____ Age _____ Gender _____ Relationship _____
Do you have a history of neglect, and/or physical, verbal, emotional, or sexual abuse?

_____
_____

Do you have a family history of substance abuse, mental illness, suicide, or violence?

_____

_____

Developmental History

Did you walk, talk, and read on time?

_____

_____

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?

_____

_____

Social and Recreational History

Describe your relationship with peers and/or friends?

_____

_____

Describe your hobbies/interests:

_____

_____

Relationship History

Are you currently in a romantic relationship? ☐Yes ☐No

If applicable, what is the date you were married, separated, divorced or widowed? _____

If you are or were married please briefly describe nature of your marital relationship/separation/divorce:

_____

_____

_____

_____

Please list any previous marriages/significant relationships from age 18 including current with name, date and the nature of the relationship.

_____

_____

_____

Do you have children? ☐Yes ☐No

If yes, list each child's name, age, gender and the nature of the relationship.

_____

_____

_____

_____

Are there presently any child custody issues involving you or your family? ☐Yes ☐No

Does your family currently have Child Protective Services Involvement? ☐Yes ☐No

If yes, what is the name and number of your caseworker? (They will not be contacted without your consent.)

_____

_____

_____

Spirituality

Do you have any spiritual beliefs that you wish to include in therapy?

_____

_____

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Legal and Military History

Do you currently have any pending criminal charges? ☐Yes ☐No

Are you on probation? ☐Yes ☐No

If yes, what is the name, county and phone number of your probation officer? (They will not be contacted without your consent.)

_____

_____

If you are on probation, will you give consent for your probation officer? ☐Yes ☐No

Have you ever been arrested/convicted of a crime? ☐Yes ☐No

If yes, complete this chart:

List any Arrests/Convictions	Date of Arrests/Convictions	Outcome

List any involvement in any legal cases. (Bankruptcy, divorce, lawsuits, etc.)

_____

Have you ever been in the military? ☐ Yes ☐ No

If yes, what branch and rank? ☐N/A

_____

_____

Any additional Information

_____

Educational History

When attending school where you: ☐Regular classes ☐Home Study ☐Cyber School ☐Special classes ☐Advanced classes ☐Other

Did you have any problems in school? (Suspension, dropped out, learning disability, etc.)

_____

_____

What is the highest education level you achieved and when did you achieve it?

_____

Any additional educational information? (College major, GED, etc.)

_____

_____

Employment History

What is your current employment status? ☐Employed Full-Time ☐Employed Part-time ☐Unemployed ☐Self-employed ☐Student ☐Other

Are you satisfied with your employment? If not, why?

_____

_____

In what fields have you worked?

_____

_____

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Substance Abuse History

Are you currently or have you ever struggled with substance abuse? ☐Yes ☐No

If you answered yes, complete the following chart: ☐N/A

Substance Used	Age of First Use	Amount Used	Frequency of Use	Date of Last Use	How was it used?

Complete the following chart if you have ever received treatment for substance abuse. ☐N/A

Name of Treatment Program	Type of Treatment	Date of Treatment	Outcome

Additional Information

Summarize your goals for counseling/therapy:

_____

_____

Do you have any cultural concerns? If so, what?

_____

_____

Is there any additional information that you believe is important for your counselor to know in order to provide you with the best care possible?

_____

_____

_____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Counselor Signature _____ Date _____