ASSOCIATES IN FAMILY CARE

INDIVIDUAL HISTORY

Client Name:_____ Today's Date: ____ /____ /____

REASONS FOR COUNSELING:

Presenting Problems:	**When It Started:**	**How Often:**
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____

Symptoms Checklist: Rate intensity of symptoms experienced in last week to previous 3 months.

0= NONE: not present

1=MILD: impacts quality of life but doesn't affect daily functioning

2=MODERATE: significant impact on quality of life and/or daily functioning

3=SEVERE: debilitating impact across all areas of life

_____ anxiety	_____ irritability	_____ poor body image
_____ hopelessness	_____ inattentiveness	_____ panic attacks
_____ change in sleep	_____ binging/purging	_____ restlessness/hyperactivity
_____ outbursts of anger	_____ excessive spending	_____ depressed mood
_____ social isolation	_____ weight gain/loss	_____ losing track of time
_____ guilt	_____ persistent worry	_____ poor concentration
_____ worthlessness	_____ mood swings	_____ fatigue/low energy
_____ self-harm behaviors	_____ nausea, diarrhea, etc.	_____ decrease in grooming
_____ suicidal thoughts	_____ obsessions/compulsions	_____ oppositional behaviors
_____ thoughts of hurting others	_____ delusions or hallucinations	_____ loss of interest in activities

Goals For Counseling:

1)_____

2)_____

3)_____

MENTAL HEALTH HISTORY:

Personal Psychiatric History: Indicate previous counseling (Outpatient, Inpatient, Rehabilitation Facility)

1)Person/Facility Name:_____ Dates Seen:_____

Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

2)Person/Facility Name:_____ Dates Seen:_____

Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

3)Person/Facility Name:_____ Dates Seen:_____

Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

Previous Diagnoses:_____

Dates & Method of Suicide Attempts:_____

Dates & Type of Self-Harm:_____

Dates & Type of Violent Behaviors:_____

Past Abuse/Trauma (Events/Dates/Persons Involved):_____

_____

_____

Family Psychiatric History: Please indicate immediate family member's name, relation to you, and reason for counseling, psychiatric hospitalization, and/or rehab facility.

_____

_____

_____

MEDICAL HISTORY

Current Medications: Please list name, dosage, purpose, prescriber, date of next appt.

_____

_____

_____

Medical Conditions/Injuries:_____

Any developmental issues as a child:_____

Substance Abuse/Addictions: List start date, end date(if applicable), amount, frequency of use.
(Include alcohol, cigarettes, vaping, illicit drugs, gambling, excessive media(phone/tv/internet), adult material, etc.)

_____

_____

_____

_____

RELATIONAL HISTORY

Family History:

Describe Family of Origin. This includes parents, step-parents, siblings, and persons that lived with you. Write their name, relation to you, current age, & quality of relationship (examples: positive, conflictual, distant).

Any significant events in childhood?:

Family Substance Abuse/Addictions: List who, start date, end date, amount, frequency of use, impact on you.

Social History:

Current Living Arrangements: Write name, relation to you, age.

List any children not living with you & frequency seen.

Who provides you with emotional support?

Current romantic relationship (include status, length, if sexually active, & level of satisfaction with it):

Previous romantic relationships (include dates, length, reason for end of relationship(s)):

CULTURAL HISTORY

Describe your ethnicity? Your sexuality?

What are your spiritual beliefs?

How would you like those beliefs incorporated in sessions?

Current activities you participate in?

Any significant events in adulthood?

Legal History: (include dates/length of any arrests, DUI, incarcerations, etc.)

******* FILL OUT PAGE 4 IF CLIENT IS A MINOR, OR PAGE 5 FOR RELATIONSHIP COUNSELING. *******

CHILD/ADOLESCENT SECTION:

Three things you enjoy about school: _____

Three things that irritate you about school: _____

What do you hope to do for a career?_____

Who do you consider your closest friend? Why?_____

Would you consider yourself more of a leader or more of a follower? _____

Have you ever been bullied? By whom? How?_____

_____

Have you ever bullied someone? How? _____

_____

What is FUN? List things you most enjoy doing with free time. _____

_____

How well do you sleep? _____ How long do you sleep on average?_____

Describe any nightmares or recurring dreams: _____

_____

Any fears or worries? _____

Any thoughts or behaviors you repeat over & over again? _____

_____

Emotional Relationships: Describe & Rate on a scale of 1 to 10 (10 is high).

How close are you with your Mother? _____ Father?_____

If applicable, how close are you with Step-Parents? _____

How close are you with your siblings? Describe & Rate:_____

_____

Describe other close relationships:_____

_____

Who are you closest to and why?_____

Best thing that has happened in your life?_____

_____

Worst thing that has happened in your life?_____

_____

If you could change anything, what would it be?_____

_____

Relationship Counseling Section: Wedding Date (if applicable) ____ / ____ / ____

Dating Narrative: How did you two get together? How well were you and your partner received by the? other person's family?_____

_____

Family of Origin Narrative: What was your parents' marriage like? How did they communicate feelings & resolve conflict? Who/How did they discipline the kids? Anything missed from parents that you needed?

_____

_____

_____

Relationship Narrative: When was the relationship good? Why? When did it begin to change? Why?

_____

_____

_____

What is your communication like (stating needs, listening, disagreeing, expressing anger, apologizing)?

_____

_____

_____

Sex: Who initiates, how do you discuss needs/desires, any past or present abuse, any other issues?

_____

_____

Money: Who handles it? How? How was this decided? Rate 1-10 (10 is high) each's handling of money.

_____

_____

Spirituality: In what ways are you and your partner similar or different in your spiritual beliefs?

_____

_____

Parenting Narrative: Parenting styles? In what ways is parenting an issue in your relationship?

_____

_____

Major Emotional Events? (ex. miscarriages, abortions, accidents, illnesses, deaths) What has been the effect on you & the relationship? _____

_____

_____