CLIENT INFORMATION:

First Name:________________________ Middle:_________ Last: _________________________________Sex:_____ DOB:_____________

Client's Primary Caregiver(s)____ Relationship to client:________________ ____________

Caregiver/Client Primary Address:____

City:____ County:________________________________ Zip:_______________ __

Home Phone:__________________________ Work Phone:____________________________ Cell Phone:_____________________________

Client Social Security #: _________-_______-________ Are you adopted? ☐ YES ☐ NO If "YES" what is your adoption story? ________

____

Marital Status:
- ☐ Never Married
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Cohabiting

Race: (optional)
- ☐ White
- ☐ Asian
- ☐ Black
- ☐ Multi-racial
- ☐ Am. Indian or Alaskan Native
- ☐ Native Hawaiian/Pacific Islander

Ethnic: (optional)
- ☐ Puerto Rican
- ☐ Other-Hispanic
- ☐ Dominican
- ☐ Haitian
- ☐ Cuban
- ☐ None
- ☐ Mexican

MEDICAL HISTORY

Medical history:
- ☐ none
- ☐ Headaches/migraines
- ☐ Stomach aches
- ☐ Diarrhea/constipation
- ☐ Heartburn/acid reflux
- ☐ Asthma/allergies
- ☐ Seizure disorder
- ☐ Diabetes
- ☐ Cerebral palsy
- ☐ Prenatal drug exposure
- ☐ Chromosome syndrome
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Pregnancy
- ☐ Cancer
- ☐ Head injury
- ☐ Liver problems
- ☐ Thyroid problems
- ☐ Heart problems
- ☐ Kidney problems
- ☐ Tuberculosis
- ☐ Other:_____________________

Sensory: ☐ no problem ☐ vision impaired ☐ hearing impaired ☐ other:____

Ambulatory: ☐ no problem ☐ walks with difficulty ☐ uses crutches/walker ☐ wheelchair bound ☐ other:______________

Have you been treated for any medical condition in the past 12 months: ____

Current medications for physical conditions:____

Medication Details:____

HOUSEHOLD COMPOSITION

Name	Relationship	Age	Other Information

Number of people in living client's current residence:_______ Biological Family ____ Adoptive Family _____ Foster Family _____

EMPLOYMENT/EDUCATIONAL INFORMATION

Employer: ______________________ Occupation: ______________________

School:______________________ Contact:______________________ Phone: ______________

Address:______________________ City:______________________ Zip:______________

Current Grade Level:_______ ☐ Regular Ed ☐ Other ESE ☐ EBD

Highest Grade Level completed: ______________________

REFERRAL INFORMATION

Referral Source Name: ______________________ Agency: ______________________

Phone:______________________ Cell:______________________ Fax:______________________

OTHER INVOLVED AGENCIES

Case Manager:______________________ Agency:______________________ Phone:______________________

DCF/CBC Worker:______________________ Phone:______________________

DJJ Worker Name:______________________ Phone:______________________

Psychiatrist Name: ______________________Phone:______________________

Other: ______________________

ADVANCE DIRECTIVES:

I have an Advance Directive/Instruction for Mental Health Treatment. YES ☐ NO ☐

MENTAL HEALTH & MEDICAL TREATMENT HISTORY

Previous Counseling:______________________

Reason for Prior Counseling:______________________

Describe results of prior treatment:______________________

1. Any particular treatment approach or strategy that you feel worked? ______________________
2. Any particular treatment approach or strategy that you feel did not work? ______________________

Inpatient/Crisis Unit Admissions :______________________

Past Psychotropic Medications: ______________________

Current Psychotropic Medications: ______________________

Family Mental Health or Chemical Dependency History: ______________________

____

PCP NAME AND TELEPHONE NUMBER (Required): ______________________

Date of Last Physical Exam: ______________________ Findings of Exam: ______________________

____

ANY Relevant medical Conditions (diabetes, cancer, head trauma, cardiac problems etc): ______________________

____

Hospitalizations /Surgeries (dates, complications, adverse reactions, outcomes): ____

____

Results of recent laboratory tests and consultation reports: ____

____

*** * * CHILDREN AND ADOLESCENTS ONLY * * ***

Developmental History (developmental milestones met early, late or normal): ____

____

Prenatal History (medical problems during pregnancy, mother's use of medications, in utero substance exposure): _______________________

____

____

Perinatal History:(details of labor & delivery): ____

____

Postnatal History (postpartum depression /anxiety, hospital stay, interruption in bonding): __________________________________

____

____

Presenting Problem

Source of Information: Patient Parent Guardian ____________________ Grandparent Foster Parent Other_________________

Presenting Problem (include onset, duration, severity): ____

____

____

____

____

Precipitating Event (why treatment now?): ____

____

____

____

Do you ever have thoughts of hurting yourself or others (if so, please explain the last time you had these thoughts?)

Describe: ____

____

____

____

NATURE OF STRESSORS: ___ FAMILY ___ SCHOOL ___ WORK ___ HEALTH ___ OTHER ____

PSYCHOSOCIAL INFORMATION

Support Systems: ____

School/Work Life: ____

Marital History: ____

Legal History: ____

Spiritual Beliefs: ____

Cultural Considerations: ____

Strengths: ____

Barriers: ____

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Nicotine/ Tabacco					
Alcohol					
Marijuana					
Opioids / Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

TO BE COMPLETED BY ClIENT

Please circle any items in the list below that you might have interest in learning more about:

Assertiveness Training

Solution Focused Techniques

Affect Identification and Expression

Communications Training

Decision Option Exploration

Pattern Identification & Interruption

Problem Solving Skills Training

Stress Management

Cognitive Restructuring

Grief and Loss Work

Identify Personal Strengths

Engage Significant Others in Treatment

Anger Management

Supportive Therapy

Parent Training

Self/Other Boundaries Training

Environmental Restructu ring

Client Signature Date

Clinician Signature Credentials Date

PLEASE CHECK THE BOX IF YOU ARE PRESENTLY HAVING EITHER DIFFICULTIES OR PROBLEMS IN THAT AREA.

PLEASE PUT A CHECK MARK ON THOSE BOXES THAT DESRIBE CURRENT SYMTOMS. PLEASE ADD AN ASTREK (*) NEXT TO THOSE SYMPTOMS THAT HAVE BEEN GOING ON FOR MORE THAN 3 MONTHS.

☐ Trouble concentrating	☐ Anxiety	☐ Feeling panicky
☐ Nervousness	☐ Uneasy in crowds	☐ Scared for no reason
☐ Excessive worrying	☐ Mind going blank	☐ Fearful
☐ Thoughts and speech mixed up	☐ Impulse to repeat absurd behaviors	☐ Avoiding places because they are frightening
	************************************	
☐ Awakening at night or earlier than usual	☐ Having no interest in things	☐ Crying more often than usual
☐ Unable to have a good time	☐ Tired most of the time	☐ Feelings of hopelessness
☐ Recent weight loss or gain	☐ Depression	☐ Feeling worthless
	************************************	
☐ Feeling others are to blame	☐ Others not giving proper credit for your work	☐ Having ideas or beliefs that others do not share
☐ Feeling most people cannot be trusted	☐ Others taking advantage if you let them	☐ Being watches or talked about
	************************************	
☐ Feeling weak in parts of your body	☐ Dizziness or faintness	☐ Feeling a lump in your throat
☐ Fast heartbeat	☐ Poor appetite	☐ Nausea or upset stomach
☐ Trouble with vision or hearing	☐ Change of sensation in parts of body	☐ Trouble getting your breath
☐ Headaches	☐ Tremors	☐ Hot or cold spells
	************************************	
☐ Bothered by unusual odors	☐ Having thoughts that are not your own	☐ Traveling somewhere without knowing how you go there
☐ Feeling things are unreal	☐ Hearing voices that others do not hear	☐ Feeling something is wrong with your mind
☐ Never feeling close to other people	☐ Having strange and peculiar experiences	☐ Seeing things that others do not see
	************************************	
☐ Urges to break or smash things	☐ Urges to harm someone	☐ Being "On top of the world" for no reason
☐ Restlessness	☐ Easily irritated	☐ "Losing it"
☐ Temper outbursts	☐ Trouble controlling impulses	☐ Being a hothead
☐ Feelings of "wanting to end it all"	☐ Having made a suicide attempt	☐ Wanting to hurt yourself
☐ Wanting to hurt someone else		
	************************************	
☐ Financial problems	☐ Difficulty reading	☐ Having an unwanted habit
☐ Unable to keep/find a job	☐ Difficulty in school	☐ Unhappy with present job
☐ Marital problems	☐ Recent divorce	☐ Recent death or loss
☐ Using drugs	☐ Legal problems	☐ Using alcohol
	************************************	
☐ Getting along with others	☐ Feeling inferior to others	☐ Worried about sex matters
☐ Home conditions bad	☐ Making decisions	☐ Having been abused
☐ Socializing	☐ Communicating	☐ Feelings being easily hurt

Positive Growth
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ADDITIONAL NOTES

CLIENT SIGNATURE	DATE	CLINICIAN SIGNATURE	DATE