CENTURY MENTAL HEALTH, INC.

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CLIENT HISTORY FORM

The following information is requested to help your therapist develop an initial understanding of the issues for which you are seeking counseling. You may leave questions unanswered if you do not know an answer or are uncomfortable providing the information. These forms will remain confidential unless subpoenaed by court.

Client Name _____ **Today's date** _____

Presenting Problem (reason you are seeking counseling):
Please provide a brief description of the problems you are experiencing:

_____
_____
_____
_____

How long have you been experiencing these problems? If possible, provide the approximate time period during which you first began to have concerns about these issues and what may have triggered them.

_____
_____
_____

Psychiatric/Mental Health History
Have you received previous counseling for these or other concerns? Yes No
Approximate dates of treatments _____

Have you ever been hospitalized for mental health issues? Yes No
Approximate dates of treatment _____

Is there a family history of psychiatric problems? Yes No
Please provide your relationship of family member and the diagnosis/es.

_____
_____

Have you experienced any trauma (direct exposure/been witness to actual or threatened death, serious injury, or sexual violence) recently or in the past? Yes No
If so, please provide a brief description and time frame of the events/s.

_____
_____
_____
_____

Have you suffered any recent losses, emotionally distressing events, or changes in life circumstances?
If so, please provide a brief description and a time frame of the event/s.

_____

_____

_____

Medical Conditions/history:
Please list your current medical providers:
Primary Care Physician _____
Psychiatrist _____
Other relevant medical specialist/s _____

Please provide a brief explanation of any chronic medical conditions:

_____

_____

Have you experienced any significant injuries, traumatic illnesses, surgeries, allergies, hospitalizations or suffered with any physical abnormalities recently or in the past?
If so, please provide a brief explanation.

_____

_____

Substance Use History

Have you received substance abuse treatment?	Yes	No
If so, please provide approximate dates._____		
Do you drink alcohol?	Yes	No
Approximately how many drinks per week:_____		
Do you use any non-prescribed drugs other than alcohol?	Yes	No
Has anyone ever suggested you may have a problem with alcohol/substance use?	Yes	No
Is there a history of substance abuse in your family?	Yes	No

Family History
What best describes your upbringing?
_____Raised by birth parents in an intact marriage.
_____Raised by divorced birth parents.
_____Raised by divorced parents and stepparents.
_____Raised by single parent.
_____Raised by widowed parent.
_____Adopted: raised in an intact marriage
_____Adopted, raised by divorced parents.
_____Raised in foster care.
_____Raised primarily by another: relationship.:_____

If parents were divorced, what age were you at time of divorce? _____

If parents/caregivers are deceased, please date of death. _____

How many siblings do you have? Please indicate their ages.

_____

_____

What is your birth order? _____

How satisfied are you with the support you receive from your family?
Very unsatisfied Unsatisfied Satisfied Very satisfied

Were there any significant financial, legal, social, or medical stressors that your family experienced? Please describe. _____

_____

Briefly describe your relationship with your parents/caregivers.

_____

_____

_____

Briefly describe your relationship with your siblings.

_____

_____

_____

Relationship History:
Are you currently:
_____Married _____In a committed partnership_____Separated/Divorced____Widowed___Single

Date met current or most recent partner/spouse. _____
Date married/committed partner/spouse. _____
Date widowed. _____

Are you currently experiencing difficulty in your relationship? Yes No

History of previous relationships:

Partner	Date committed	Date separated.
	_____	_____
	_____	_____

Spouse	Date committed	Date separated.
	_____	_____
	_____	_____

If you have any children, please list ages and gender of your children. Please indicate if step or adopted.

_____

_____

_____

_____

Social History

Are you active in any social/civic/religious organizations? Yes No

If so, please list. _____

Are you able to enjoy leisure/recreational activities? Yes No

If no, why _____

If so, what activities bring you pleasure? _____

_____

How satisfied are you with the support you receive from friends?

_____Very unsatisfied _____Unsatisfied _____Satisfied_____Very satisfied

Developmental History

Provide a brief explanation of any significant developmental delays/learning difficulties in childhood:

_____

_____

Educational/Occupational History:

Highest level education:

High School: ____ Attended____Graduate

College:_____ Attended _____Associate's____Bachelor's_____Master's/Doctorate.

Current Employer: _____

Job Title: _____

Legal History:

Are you currently involved in any legal proceedings? Yes No

If so, please indicate the nature of the legal proceeding:

Family/divorce/custody: _____

Criminal:_____

Civil: _____

Do you have any previous convictions? Yes No

Military History

Describe any military service (date, branch, discharge status, etc.)

_____

Cultural History

Do you consider yourself part of a cultural or ethnic group and if so, is there anything about your cultural beliefs which you would like your therapist to be aware?_____

_____

_____

Please complete the symptom checklist
Check the symptoms you are currently experiencing or have experienced in the last 6 months.

Physical
_____Insomnia
_____Too much sleep
_____Headaches
_____Weight loss
_____Weight gain
_____Bladder/Bowel control
_____Shaky/Jittery
_____Loss of appetite
_____Low energy
_____Impaired Sexual Functioning

Emotional/Mood
_____Angry
_____Depressed
_____Tired
_____Withdrawn
_____Lonely
_____Grief
_____Feeling inferior
_____Irritable
_____Lack of interest
_____Detached
_____Elevated/High mood
_____Drastic and quick mood changes
_____Nervous
_____Stressed
_____Phobic
_____Worry a lot
_____Panicky
_____Easily frustrated
_____Tense

Behavioral
_____Impulsive
_____Lethargic
_____Hyperactive
_____Physically abusive
_____Verbally abusive/threatening
_____Problems with drugs/alcohol
_____Cheating/lying
_____Legal problems
_____Sexual problems
_____Unassertive
_____Blaming of Others
_____Uncommunicative
_____Letting others take advantage of you
_____Compulsive (repetitive urges)
_____Overly dependent on others
_____Suspicious
_____Controlling /domineering
_____Demanding
_____Oppositional
_____Irresponsible
_____Lack self-control
_____Violent
_____Temper outburst
_____Failing at school
_____Behavior problems at school
_____Attention seeking
_____Sexual issues
_____Work difficulties
`_____Hostility
_____ Overeating
_____Binging/purging
_____Gambling excessively

Thoughts
_____Suicidal thoughts
_____Homicidal thoughts
_____Wanting to hurt oneself
_____Difficulty concentrating
_____Feelings of unreality
_____Forgetfulness
_____Lack self-esteem.
_____Obsessive thoughts
_____Racing Thoughts
_____Seeing/hearing things that aren't there

Relationships
_____Difficulty expressing affection
_____Difficulty receiving affection
_____Difficulty setting limits
_____Difficulty Initiating social contact
_____Difficulty feeling connected

Other _____