

History Report

Today's Date: _____

DX: _____

Patient #1 _____ Sex: _____ Phone: Home _____
 First Middle Last Work _____
 Address _____ Cell _____
 Email: _____

Mailing Address if different _____

School or Employment _____ DOB _____ Birthplace _____ Age _____

Address of School or Employment _____

Job Title _____ Or Grade in School _____ Social Security # _____

Marital Status: Single Married Divorced Separated Co-Habitat Years Married _____ to whom? _____

Partner #2 _____ Sex: _____ Phone: Home _____
 First Middle Last Work _____
 Address _____ Cell _____
 Email: _____

Mailing Address if different _____

School or Employment _____ DOB _____ Birthplace _____ Age _____

Address of School or Employment _____

Job Title _____ Or Grade in School _____ Social Security # _____

Marital Status: Single Married Divorced Separated Co-Habitat Years Married _____ to whom? _____

Family History: **Include ALL members of household & family INCLUDING THOSE NOT LIVING WITH YOU OR DECEASED**
Significant other, mom, dad, grandparents, step parents, siblings, children, & stepchildren. If retired what did they do when employed.

NAME FIRST & LAST	RELATIONSHIP TO CLIENT	DOB	AGE	EMPLOYMENT OR SCHOOL TITLE/NAME	EDUCATION LEVEL	BIRTH ORDER	DECEASED AGE OR YEAR

Driver's License # _____ State _____

Contact person in emergency (not living with you) _____ Name _____

Address _____ Telephone _____ Phone _____ Bank _____

Physician _____ Telephone _____ Phone _____ Bank _____
 Referral Source _____ Reason for appointment _____
 (i.e. internet, friend, doctor, phone book, etc.)

1. Do you drink coffee/tea? **Yes** **No**
If yes, how much and how often?
2. Do you drink alcoholic beverages? **Yes** **No**
If yes, what do you drink most often and how often?
3. Do you smoke cigarettes or marijuana? **Yes** **No**
If yes, how much do you smoke per day?
4. Do you take any medications on a regular basis?
If yes, what and why? **Yes** **No**
5. Are you on any medication at the present?
if yes, what and why? **Yes** **No**
6. Do you take vitamins regularly? **Yes** **No**
If yes, what vitamins and how often?
7. What are your favorite foods?
8. Which foods do you eat most often?
9. How many meals_____snacks_____do you eat a day?
10. How much exercise do you get a week? Type?
11. Describe yourself, as you perceive yourself.
12. Describe yourself, as others perceive you.
13. What are 3 things you like most about yourself?
A.
B.
C.
14. What are 3 things you like least about yourself?
A.
B.
C.
15. Describe your personal responsibilities briefly.
16. What activities do you enjoy? Things you do alone and/or with others?
17. Do you have any close relationships or friendships? **Yes** **No**
If yes, with whom?

Circle all that apply.

18. Household depends on income of: Man Woman Child Parent Other_____
19. I am committed to attending regular therapeutic sessions. **Yes** **No**
20. I am willing to take on pre-counseling diagnostic evaluation test to establish my baseline psychological level*.
* **MMPI** (Minnesota multiple Personality Inventory) **Required of ALL new clients.** **Yes** **No**

IF PARTICIPATING MARITAL/PARTNER COUNSELING, PLEASE ANSWER QUESTIONS 1-6

1. What are 3 things you like about your spouse or partner?
- A.
- B.
- C.
2. What are 3 things you like least about your spouse or partner?
- A.
- B.
- C.
3. I am willing to come to marital counseling sessions on a regular basis. **Yes** **No**
4. Whose idea was it to come for marital counseling? **Female** **Male** **Both**
5. Who will be responsible for payment? **Female** **Male** **Both**