# 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 |
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Driver's License #_____ State_____

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

_____
Address Phone

Physician_____ Telephone_____ 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? **Yes** **No**
   if yes, what and why?

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**

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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**