Alaska Center for Counseling

Client's Personal History

Name: _____ Gender: M:___ F:___ DOB:____/____/_____

Address: _____ City: _____ State: ____ Zip: _____

Email Address:_____ Phone Number: _____

Can we leave voicemails and/or text messages to this number? Voicemails: ___ Texts: ___ Neither: ___

Emergency Contact: _____ Phone Number: _____

Primary reason(s) for seeking services: _____

_____

_____

If you need any more space for any of the questions, please use the back of this sheet.

Family History

	Name:	Age:	Living/Deceased:	Living w/you?
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Spouse or S/O:	_____	_____	_____	_____
Children:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Marital Status

Single: ___ Duration: _____ Married: ___ Duration: _____

Divorced: ___ Duration: _____ Separated: ___ Duration: _____

In a relationship: ___ Duration: _____ Number of marriages: _____

Assessment of current relationship (if applicable): Good: ___ Fair: ___ Poor: ___

Development

Are there any special, unusual, or traumatic circumstances that affected your development?Yes___ No___

If yes, please describe: _____

_____

Parental Information

Parents Married: ___ Parents have never been separated: ___ Parents separated: ___ Parents divorced: ___

Special circumstances (e.g., raised by person other than parents, relatives, foster parents, etc.): _____

_____

Military and Deployment

Military? Yes: ___ No: ___ Combat experience? Yes: ___ No: ___ Branch: _____

Where: _____ Date drafted: _____ Date discharged: _____

Date enlisted: _____ Rank at discharge: _____

Are there any special, unusual, or traumatic circumstances that affected your development?Yes___ No___

If yes, please describe: _____

_____

Spiritual/Religious

How important to you are spiritual matters? Not: ___ Little: ___ Moderate: ___ Very: ___

Are you affiliated with a spiritual or religious group? Yes: ___ No: ___

If yes, describe: _____

Were you raised within a spiritual or religious group?Yes: ___ No: ___

If yes, describe: _____

Would you like to have your spiritual/religious beliefs incorporated into the counseling? Yes: ___ No: ___

If yes, describe: _____

Current Legal Status

Are you involved in any active cases (traffic, civil, criminal)? Yes: ___ No: ___ DUI: Yes: ___ No: ___

If yes, describe: _____

Are you presently on probation or parole? Yes: ___ No: ___

If yes, describe: _____

Current Employment Status and Occupation

Employment Status: Employed: ___ Unemployed: ___ Occupation: _____

Employer: _____ Dates Employed: _____

Education

Are you currently enrolled in school? Yes: ___ No: ___ High School Graduate/GED: Yes: ___ No: ___

College Institution: _____ Duration: _____

Graduated:Yes: ___ No: ___ Major: _____ Minior: _____

Graduate Institution: _____ Duration: _____

Graduated:Yes: ___ No: ___ Major: _____

Special circumstances (e.g., learning disabilities, gifted): _____

_____

Leisure/Recreational

Describe special areas of interest/hobbies (e.g. art, books, church activities, exercise, hunting, fishing, etc)

Activity: How often now? How often in the past?

_____

_____

_____

Medical and Physical Health

___ AIDS/HIV
___ Alcoholism
___ Abdominal Pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed Wetting
___ Cancer
___ Chest Pain
___ Chronic Pain
___ Cough
___ Constipation
___ Covid
___ Chicken Pox
___ Dental Issues
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug Abuse
___ Epilepsy
___ Ear Infections
___ Eating Issues
___ Fainting
___ Fatigue
___ Frequent Urination
___ Headaches
___ Hearing Issues
___ Heart Disease
___ Hepatitis
___ High Blood Pressure
___ Kidney Issues
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual Pain
___ Miscarriages
___ Neurological Disorders
___ Nausea
___ Nose Bleeds
___ Pneumonia
___ Rheumatic Fever
___ STD's
___ Sleep Disorders
___ Sore Throat
___ Scarlet Fever
___ Sinusitis
___ Stroke
___ Sexual Issues
___ Tonsillitis
___ Tuberculosis
___ Thyroid Issues
___ Vision Issues
___ Vomiting
___ Whooping Cough
___ Other (Specify)

List any recent health or physical changes: _____

_____

Current Medications: _____

_____

Last Doctor's Visit Date/ Reason: _____

Upcoming or Past Surgeries: _____

Mental and Physical Health Continued

Please check if there have been any recent changes in the following:

___ Behavior ___ Energy Level ___ Nervousness/Tension ___ Physical Activity

___ Eating Patterns ___ General Disposition ___ Sleep patterns ___ Weight

___ Emotional Regulation

Describe changes in areas in which you checked above: _____

_____

_____

Chemical Use History

Alcohol, Barbiturates, Valium/Librium, Cocaine/Crack, Heroin/Opiates, Marijuana, PCP/LSD, Inhalants, Caffeine, Nicotine, Over the Counter, Prescription Drugs, Other Drugs.

Name: _____ Frequency of use: _____

Method of use and amount: _____ Age of first use: ___ Age of last use: ___

Used in the last 48 hours: ___ Used in the last 30 days: ___

Name: _____ Frequency of use: _____

Method of use and amount: _____ Age of first use: ___ Age of last use: ___

Used in the last 48 hours: ___ Used in the last 30 days: ___

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends: _____

_____

How do you believe your substance use affects your life? _____

_____

Who or what has helped you in stopping or limiting your use? _____

Does anyone in your family have or have had a problem with drugs or alcohol? Yes: ___ No: ___

If yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? Yes: ___ No: ___

If yes, describe: _____

Have drugs/alcohol affected your job? Yes: ___ No: ___ If yes, describe: _____

_____

Counseling/Prior Treatment

Counseling/Psychiatric: Yes: ___ No: ___ Duration: _____ Where: _____

Outcome: _____

Drug/alcohol treatment: Yes: ___ No: ___ Duration: _____ Where: _____

Outcome: _____

Groups(e.g. AA, NA , etc): Yes: ___ No: ___ Duration: _____ Where: _____

Outcome: _____

Suicide attempts/thoughts: Yes: ___ No: ___ Frequencey of thoughts: _____

Number of attempts: _____ Age first attempted: ____ Age last attempted: ____

Do you feel suicidal at this time? Yes: ___ No: ___ If yes, explain: _____

_____

Please check behaviors, symptoms, and feelings that occur more often than you would like them to take place:

___ Aggression	___ Dizziness	___ Hopelessness	___ Sexual Addiction
___ Alcohol Dependence	___ Distractibility	___ Irritability	___ Sexual Difficulties
___ Anger	___ Drug Dependence	___ Impulsivity	___ Sick Often
___ Anxiety	___ Eating Disorder	___ Judgment Errors	___ Sleeping Problems
___ Avoiding People	___ Elevated Mood	___ Loneliness	___ Speech Problems
___ Chest Pain	___ Fatigue	___ Memory Impairment	___ Suicidal Thoughts
___Cyber Addiction	___ Gambling	___ Mood Shifts	___ Trembling
___ Depression	___ Hallucinations	___ Panic Attacks	___ Withdrawing
___ Disorganized Thoughts	___ Heart Palpitations	___ Phobias/Fears	___ Worrying
___ Disorientation	___ High Blood Pressure	___ Recurring Thoughts	___ Other (Specify)

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

What are your goals for therapy? _____

_____

_____

Name if form was completed by someone other than the client: _____

How did you hear about us? _____

Date form was completed: _____

For Staff Use

Therapist's Signature/Credentials: _____ Date: _____

Therapist's Comments: _____

_____

_____

Supervisor Comments: _____

_____