Alliance Counseling & Coaching

25224 W. Eames Street
Channahon, IL 60410
815-467-8181

862A Center Court
Shorewood, IL 60404
815-255-2215

HISTORY FOR THERAPY ASSESSMENT

IDENTIFYING INFORMATION:

Client:

Name_____Date_____

Address_____

City/State/Zip:_____

Home phone:_____ Cell phone:_____

Age_____Date of Birth_____Gender_____Marital Status_____

Social Security Number:_____

Insurance Policy Holder:

Name_____Date of Birth_____

Address_____Phone:_____

Social Security Number:_____

Emergency Contact:

Name_____Relationship_____

Phone:_____

Do we have your consent to leave messages on voicemail (Circle Preference) Home Cell

If no please indicate no _____

How did you hear about Alliance Counseling & Coaching?

Internet Phone book Doctor Friend Other:_____

SYMPTOMS/LIFE ISSUES:

___Headaches	___Depressed	___Feel panicky	___Sexual Problems
___Hands shake	___Tiredness	___Shy	___Home conditions bad
___Vision problems	___Can't relax	___Can't make decisions	___Can't keep job
___Bowel disturbance	___Can't sleep	___Feel Tense	___Financial problems
___Stomach trouble	___Fainting spells	___Unusual Feelings	___Alcoholism
___Fast Heartbeat	___Hearing difficulty	___Overambitious	___Drugs
___Dizziness	___Feel inferior	___Lonely	___In-law problem

Do any of the following describe you:

Specific fears	Tremors	Panic attacks	Lightheadedness
Obsessions/Compulsions	Doom	Agoraphobia	Numbness
Anxiety	Palpitations	Nervousness	

If yes, describe how:_____

Presenting issue for counseling:_____

PREVIOUS MENTAL HEALTH TREATMENT:

Therapist	Location	Dates	Outcome

PSYCHIATRIC HOSPITALIZATION? (List All)

Psychiatric Hospital	Date	Reason for Admission	Length of Stay

Suicidal thoughts: Past? Present? Explain:_____

_____

Suicidal attempts: Method Used?_____When?_____

Where?_____How was it stopped?_____

Hospitalization?_____

Please Explain:_____

CURRENT PSYCHIATRIC MEDICATIONS:

Name	Type/Purpose	Dosage Taken	Frequency Taken

History of mental illness in family Yes No If Yes, describe:_____

CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:

(ie. Allergies, seizures, high blood pressure, diabetes, cardiac problems TB, etc)_____

_____

_____

Name of Medical

Doctor_____Phone:_____

Name of Psychiatrist_____Phone:_____

Date of last physical exam:_____Where:_____Doctor:_____

CURRENT MEDICATIONS, VITAMINS, & OVER THE COUNTER:

Name	Purpose	Dosage Taken	Frequency Taken	Prescribed by

Health Behavior (Be specific, No. of ounces, etc.):

Nicotine_____ Caffeine_____Beer_____Wine_____

Liquor_____Marijuana_____Speed/Downers_____Other drugs_____

Prescription medications:_____

Nutrition ☐ Poor ☐ Adequate ☐ Excellent If poor, please explain_____

Exercise ☐ Poor ☐ Adequate ☐ Excellent If poor, please explain_____

FAMILY DATA:

FAMILY OF ORIGIN:

	Name	***Birth date***	***Age***	***Sex***	***Living or Dead***	***Marital Status***
SPOUSE						
CHILDREN						
FATHER						
MOTHER						
BROTHERS and/or SISTERS						
OTHERS: (Stepbrothers & Sisters, Ex-Spouse, etc.)						

Describe each parent in three words (indicate if step-parent):

Mother_____ _____ _____

Father_____ _____ _____

Which parent are you closest to?_____

Describe relationship with parents. Past/Current_____

_____

Describe parents relationship to each other_____

_____

What is your birth order?_____

Describe past/current relationship with siblings_____

_____

Any history of physical/sexual/emotional abuse? Yes No Describe:_____

_____

Did you have a best friend as a child?_____

Describe friends as an adult:_____

_____

Describe significant life events:_____

_____

Have you lost someone through death?_____

How did you handle situation?_____

_____

Sexual History:

Describe your parents attitudes towards sex:_____

How did you learn about sex:_____

Any frightening or unpleasant sexual experiences?_____

Any abuse or trauma?_____

If applicable: Pregnancies_____ Miscarriages_____ Abortions_____

(Number of each)

Work History:

Are you currently employed?_____If so where?_____

Type of work or career?_____

If employed, do you like your job?_____

Martial History:

Number of Marriages:_____Date(s)_____

Does your marriage need improvement?_____

_____

Concerns you have regarding your marriage:_____

_____

Describe your relationship with your children:_____

_____

Concerns you have regarding your children:_____

_____

If single, attitude towards single status:_____

_____

Religion

Describe how your religious beliefs influence your life:_____

_____

Education

Current/highest grade obtained_____

Legal

Any current legal problems? (ie, court order, probation/parole, guardianships, arrest, order of protection):_____

_____

_____

Please list your strengths:

_____

_____

_____

Anything else you feel your counselor should know about you?_____

_____

_____

_____

_____

_____

_____

_____