

Alliance Counseling & Coaching

Channahon - Joliet - Plainfield

HISTORY FOR THERAPY ASSESSMENT

Client Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

How did you hear about Alliance Counseling & Coaching?

- | | |
|---|---|
| <input type="checkbox"/> Returning client | <input type="checkbox"/> Family/friend |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Google search |
| <input type="checkbox"/> Alliance website | <input type="checkbox"/> Psychology Today |
| <input type="checkbox"/> Dr. Referral | <input type="checkbox"/> Other: _____ |

Work History:

Are you currently employed? Yes No

If so, where? _____

Type of work or career? _____

If employed, do you like your job? _____

Education:

Current/highest grade obtained: _____

Presenting issue for counseling:

SYMPTOMS/LIFE ISSUES:

- Headaches Depressed Feel panicky Sexual problems
- Hands shake Tiredness Shy Poor home conditions
- Vision problems Can't relax In-law problem 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 Can't make decisions

Do any of the following describe you?

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

If yes, describe how: _____

PREVIOUS MENTAL HEALTH TREATMENT

Therapist	Location	Dates	Outcomes

PSYCHIATRIC HOSPITALIZATIONS (List All)

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): _____

Self harming behavior: Past Present

Explain: _____

CURRENT PSYCHIATRIC MEDICATIONS:

Name	Type/Purpose	Dosage	Frequency Taken

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

CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:

(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	Frequency Taken	Prescribed by

Health Behavior: (Please be specific-Frequency/Amount, Etc.)

- Nicotine: _____
- Caffeine: _____
- Beer: _____
- Wine: _____
- Liquor: _____
- Marijuana: _____
- Speed/Downers: _____
- Other drugs: _____

Nutrition: Poor Adequate Excellent

If poor, please explain: _____

Exercise: Poor Adequate Excellent

If poor, please explain: _____

Sleep Issues: (night terrors, insomnia, etc.) Yes No

Explain: _____

FAMILY DATA/HISTORY:

	Name	Birth Date	Age	Sex	Living or Dead	Marital Status
Spouse						
Children						
Father						
Mother						
Siblings						
Step Siblings						

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

Mother: _____

Father: _____

Which parent are you closest to? _____

Describe past/current relationship with your parents:

Describe parent's relationship to each other:

What is your birth order? _____

Describe past/current relationship with siblings: _____

Any history of physical/sexual/emotional abuse? Yes No

Explain: _____

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 the situation? _____

Martial History:

Number of Marriages: _____ Date(s): _____

Does your marriage need improvement?

Concerns you have regarding your marriage: _____

If single, describe your attitude towards single status: _____

Sexual History:

Describe your parent's attitudes towards sex:

How did you learn about sex?

Have you had any frightening or unpleasant sexual experiences?

Any abuse or trauma?

If applicable, number of Pregnancies: _____ Miscarriages: _____ Abortions: _____

Children:

Describe your relationship with your children:

Concerns you have regarding your children:

Religion:

Describe how your religious beliefs influence your life: _____

Legal:

Any current legal problems? (court orders, probation/parole, guardianships, arrest, order of Protection, DCFS)

Additional Information:

Please list your strengths:

Anything else you feel your counselor should know about you?
