
COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs.

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?

Yes No

If yes, please describe: _____

Have any of your family members or friends ever attempted or committed suicide?

Yes No

If yes, who and when: _____

MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

Are you currently receiving any traditional or non-traditional medical treatment? Yes No If yes, please describe and note providers: _____

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)

Name of medications	Dose	Reason for taking

Prescribing Doctor: _____ Date and outcome of last physical exam: _____

Are you taking these medications according to the doctor's recommendations? Yes No If no, please explain below:

PRESENT ISSUES AND GOALS

Check any of the following symptoms or problems that you currently are or recently have experienced:

<input type="checkbox"/> Stress	<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Seeing Things Others Don't
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other Relational Problems	<input type="checkbox"/> Hearing Voices
<input type="checkbox"/> Panic	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Racing Thoughts
<input type="checkbox"/> Depression	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Apathy	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Drug Use
<input type="checkbox"/> Fatigue/Lack of Energy	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Loss of Appetite/Overeating	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Gender Identity Issues	<input type="checkbox"/> Abortion
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Anger	<input type="checkbox"/> Legal Matters
<input type="checkbox"/> Feeling Worthless	<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Work Stress
<input type="checkbox"/> Recent Death	<input type="checkbox"/> Bad Dreams	<input type="checkbox"/> Career Choices
<input type="checkbox"/> Grief	<input type="checkbox"/> Unwanted Memories	<input type="checkbox"/> Indecisiveness
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Loss of Control	<input type="checkbox"/> Parenting Problems
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Impulsive Behavior	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Fears	<input type="checkbox"/> Compulsive Behaviors	<input type="checkbox"/> Spiritual Problems
<input type="checkbox"/> Shyness	<input type="checkbox"/> Controlled by Others	<input type="checkbox"/> Other
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Obsessive Thoughts	_____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

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Very Minimally Distressed	Moderately Distressed	Very Extremely Distressed
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- Are you currently experiencing any suicidal thoughts? Yes No
- Have you experienced suicidal thoughts in the past? Yes No
- Have you attempted suicide in the past? Yes No
- Are you currently experiencing any violent or homicidal thoughts? Yes No

INTENT FOR THERAPY

Please write a 2-3 paragraph summary of the issues you want to work on. Why are you seeking counseling and what are your goals? In the instance of Couples/Family Therapy, BEFORE submitting these forms to Gretchen, SHARE this summary with your partner/family.