CHARIS Counseling Associates
CONFIDENTIAL HISTORY INFORMATION (Adult)

CLIENT NAME: _____

What has led you to seek counseling or evaluation at this time: _____

_____

When did these concerns or struggles develop: _____

Have you ever attempted suicide or made any self-harm attempts: YES NO

If yes, how long ago was the last attempt: _____

Do you have current thoughts of ending your life or harming yourself: YES NO

If yes, what is your plan: _____

Do you have current thoughts of harming anyone else: YES NO

If yes, what is your plan: _____

Are you currently experiencing overwhelming sadness, grief, or depression? YES NO

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? YES NO

If yes, when did you begin experiencing this? _____

What significant life changes or stressful events have you experienced recently:

_____

Support System: Who can you count on for support: *(please circle all that apply)*

Parents	Spouse	Significant Other	Self Help Group	Employer	Church
Therapist	Neighbor	Extended Family	Close Friend	Pastor	Siblings
Co-Worker	Medical Doctor	Other: _____			

Symptoms, Specific Concern or Problem Areas: *(Please circle any that are currently troubling you)*

Abortion	Depression	In-laws	Self-Esteem
Addictions	Divorce	Legal Matters	Separation
Adoption	Dreams	Loneliness	Sexual Abuse/Rape
Alcohol Use	Drug Use	Loss of Control	Sexual Addiction
Ambition	Eating Disorder	Loss of Trust	Sexual Issues
Anger/Temper	Education	Low Energy	Shyness
Anxiety	Emotional Abuse	Marriage	Single parent
Apathy	Employment/Job Problems	Medication/Drug Issues	Singleness
Appetite/Weight	Energy	Memories	Sleep
Bitterness/Resentment	Envy/Jealousy	Mid-life	Spouse Abuse
Burnout/Stress	Family Issues	Mother Issues	Stomach Problems
Change in Life	Father Issues	Nervousness	Stress
Child Abuse	Fear	Nightmares	Substance Abuse
Child/Parenting/Discipline	Finances/Debt	Panic Attacks	Suicidal Thoughts
Child/Rebellion	Forgiveness	Physical abuse	Thoughts
Child/Schooling	Friends	Poor Concentration	Tiredness
Communication	Frustration	Poor Memory	Unemployment
Concentration	Grief	Pornography	Unhappiness
Confusion	Guilt	Rejection	Violence/Rage
Crisis	Health/Medical	Relaxation	Withdrawal
Death	Inferiority	Religion/Spiritual Issues	Work
Decisions	Infidelity	Self-Control	Worry

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CONFIDENTIAL HISTORY INFORMATION (Adult)

PREVIOUS COUNSELING OR MENTAL HEALTH TREATMENT

Have you ever been in counseling before? YES NO

Have you ever been hospitalized for a mental health or addiction reason? YES NO

If yes to either of the above questions, please describe it below. Start with most recent time first.

A. When was the counseling or hospitalization? _____

Where did you go? _____ Name: _____

Explain what happened: _____

_____

What was helpful to you: _____

B. When was the counseling or hospitalization? _____

Where did you go? _____ Name: _____

Explain what happened: _____

_____

What was helpful to you: _____

What are the *current* prescription medications you are taking?

MEDICATION	DOSE	PRESCRIBING PHYSICIAN

In the past, which psychiatric medications were prescribed for you?

MEDICATION	DOSE	APPROXIMATE DATE

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for you?

YES NO *If yes, please describe* _____ date: _____

RELATIONSHIPS

Are you currently in a romantic relationship YES NO If yes, for how long? _____

On a scale of 1-10, (1 = needs work, 10 = outstanding) how would you rate your relationship? _____

Your current Marital Status *(please circle):*

NEVER MARRIED DOMESTIC PARTNERSHIP MARRIED SEPARATED DIVORCED WIDOWED

Please list any children and their ages: _____

_____

_____

Specific Concerns you have for your children: _____

_____

CHARIS Counseling Associates
CONFIDENTIAL HISTORY INFORMATION (Adult)

FAMILY OF ORIGIN

Parents' marital status: NEVER MARRIED MARRIED SINGLE DIVORCED WIDOWED SEPARATED OTHER:

How would you describe their relationship? EXCELLENT GOOD FAIR POOR N/A

Mother's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____ Your age at the time of her death _____

Describe your relationship with your Mother: EXCELLENT GOOD FAIR POOR N/A

Father's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____ Your age at the time of his death _____

Describe your relationship with your Father: EXCELLENT GOOD FAIR POOR N/A

Do you have stepparents? YES NO

Describe your relationship with your Stepparents: EXCELLENT GOOD FAIR POOR N/A

List members of your family of origin and how you get along with each one:

Family member	Age	Relationship	Comment

What was your birth order: ___ of ___ children. Who primarily raised you _____

How would you describe your childhood: TRAUMATIC PAINFUL UNEVENTFUL LOVING JOYFUL OTHER *Please explain*:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If YES, please indicate the family member's relationship to you in the space provided (father, grandmother, brother, uncle, etc.).

Alcohol/Substance Abuse	YES	NO	_____
Anxiety	YES	NO	_____
Attention Deficit	YES	NO	_____
Bipolar Disorder	YES	NO	_____
Depression	YES	NO	_____
Divorce	YES	NO	_____
Domestic Violence	YES	NO	_____
Eating Disorders	YES	NO	_____
Extremely Critical	YES	NO	_____
Hyperactivity	YES	NO	_____
Obesity	YES	NO	_____
Obsessive Compulsive Behavior	YES	NO	_____
Over Controlling	YES	NO	_____
Poverty	YES	NO	_____
Schizophrenia	YES	NO	_____
Suicide Attempts	YES	NO	_____

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CONFIDENTIAL HISTORY INFORMATION (Adult)

GENERAL HEALTH INFORMATION

Please list your primary care doctor, address and phone: _____

_____

_____

How would you rate your current physical health? *(please circle)*

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please circle all currently difficulties that you are currently experiencing:

Accidents	Dizziness	Hypertension	Sleep problems
Anorexia/bulimia	Don't like to be touched	Indigestion	Stomach problems
Arthritis	Dry mouth	Infections	Stroke
Back injury/pain	Eating patterns	Influenza	Surgeries
Blackouts	Excessive sweating	Muscle spasms	Tension
Blood pressure (high or low)	Fainting spells	Nausea	Thyroid
Blood sugar (high or low)	Falling	Overeating	Tics
Bowel Problems	Fatigue	Palpitations	Tingling
Burning or itchy skin	Flushes	Pneumonia	Transplants
Cancers	Hair loss	Poor appetite	Tremors
Chest pains	Headaches	Pregnancy	Twitches
Constipation	Head injury/trauma	Rapid heart rate	Unable to relax
Chronic pain	Hearing problems	Renal problems	Visual disturbances
Dementia	Heart disease	Respiratory problems	Vomiting
Diabetes	Hormone changes	Sexual problems	Watery eyes
Diarrhea	Hospitalizations	Skin problems	Weight

Please list any other major health problems or events you experienced: _____

_____

Rate your current sleeping habits? *(please circle)* POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____ Types of exercise: _____

Please circle all that you have tried or are currently using. Circle (P) if it was in the past. Circle (C) if it is current.

Acid – LSD	P	C	Crack	P	C	Meperidine	P	C	Opiates	P	C
Alcohol	P	C	Dextromethorphan	P	C	Mescaline	P	C	Oxycodone	P	C
Ambien	P	C	Diuretics	P	C	Methadone	P	C	Oxymorphone	P	C
Amphetamines	P	C	Energy drugs	P	C	Methamphetamine	P	C	Salvia divinorum	P	C
Anti-depressant	P	C	Fentanyl	P	C	Methylphenidate	P	C	Soda pop	P	C
Anti-Anxiety	P	C	Flunitrazepam	P	C	Milk	P	C	Sleep mediation	P	C
Barbiturate	P	C	GHB	P	C	Morphine	P	C	Spice	P	C
Benzodiazepines	P	C	Hashish	P	C	Mushrooms	P	C	Sport's drinks	P	C
Caffeine	P	C	Heroin	P	C	MDMA	P	C	Steroids	P	C
Codeine	P	C	Hydrocodone	P	C	Pain Relievers	P	C	Stimulants	P	C
Coffee	P	C	Inhalants	P	C	PCP	P	C	Tea	P	C
Coke	P	C	Ketamine	P	C	Propoxyphene	P	C	Tobacco	P	C
Cocaine	P	C	Marijuana	P	C	Psilocybin	P	C	Water	P	C

Have you ever felt that you should cut down on your alcohol or other drug use (including prescription drugs)? YES NO

Has a friend or relative discussed concerns about your use? YES NO

Have you had to take a drink or use a drug the next day to steady your nerves? YES NO

How often do you find that you stay online longer than you intended?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

How often do others in your life complain to you about the amount of time you spend online?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

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CONFIDENTIAL HISTORY INFORMATION (Adult)

CURRENT LIVING ARRANGEMENT / FAMILY SITUATION

Significant individuals or family members currently living with you:

Name *Gender* *Age* *Relationship to you*

_____

_____

_____

Significant individuals or family member currently NOT living with you:

Name *Gender* *Age* *Relationship to you*

_____

_____

_____

OCCUPATION

Are you currently employed? YES NO FULL TIME PART TIME

If yes, employer and occupation: _____

_____

How long employed or unemployed? _____

Do you enjoy your work? _____ What are the stressful features about your current work? _____

_____

_____

Your current approximate household income $ _____ per _____

What is your dream job? _____

LEGAL HISTORY

Have you ever been charged with a crime other than minor traffic violations? YES NO *(If yes, please explain)*: _____

_____

Have you ever been involved in domestic violence? YES NO *(If yes, please explain)*: _____

_____

Are you currently involved in a legal matter? YES NO *(If yes, please explain)*: _____

_____

EDUCATION HISTORY

What was school like for you? _____

_____

Highest level achieved? _____ What type of grades did you make? _____

What was your major? _____

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CONFIDENTIAL HISTORY INFORMATION (Adult)

SPIRITUAL AND CULTURAL

Which best describes your spiritual beliefs or worldview:

Agnostic	Hinduism	Nonreligious	Spiritual but unaffiliated
Atheist	Islam	Unitarian Universalism	Taoism
Christian	Jainism	Rastafarianism	Tenrikyo
Baha'i	Juche	Sikhism	Zoroastrianism
Buddhism	Judaism	Shinto	Other:
Cao Dai	Neo-Paganism	Spiritism	

Growing up, how would you rate your spiritual or religious experiences on a scale of 1-5 *(please circle rating):*

very harmful 1 2 3 4 5 very helpful

Would you like to discuss God in your counseling sessions? _____

Would you like to pray in your counseling sessions? _____

Describe your cultural/racial background: _____

_____

Growing up, how would you rate your cultural/racial experiences on a scale of 1-5 *(please circle rating):*

very harmful 1 2 3 4 5 very helpful

Please list any concerns, which may have affected you, in regard to spiritual or cultural experience:

_____

_____

PERSONAL

What do you consider to be some of your strengths? _____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

_____

What motivates you? _____

_____

_____

_____

What is a significant event in your life and what got you through that time (good or bad)? _____

_____

_____

_____

What would you like to accomplish with your time in therapy? _____

_____

_____

_____

_____ _____

Signature of individual giving this report *Date*