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INDIVIDUAL CONCERNS & HISTORY

NAME ____ DATE ______________________

Circle the following terms, which pertain to you or any of your family members. Indicate concerns for yourself with a "S" and concerns for family members with an "F".

Nervousness	Health Problems	Marital Problems	Drug Usage
Shyness	Stomach Problems	Divorce	Alcohol Usage
Anger	Addicted to Technology	Separation	Financial Problems
Loneliness	Depression Headaches	Affair	Problems w/Friends
Frustration	Memory Loss Sleeping	Problems w/ ex-spouse	Can't Have Fun
Temper	Problems Nightmares	Stress	Tiredness
Self-Control	No Ambition	Grief	Children
Insecurity	Eating Problems	Parenting Problems	Career Choices
Fears	Suicidal Thoughts	Relationship Problems	Problems w/Parents
Panic Attacks	Lack of Energy	Legal Problems	Chronic Pain
Isolation		Work Problems	School Problems
Can't Concentrate		Difficulties in Decision-making	

List any medical problems you have: ____

____

____

If you have noticed any <u>recent changes</u> in the following areas, <u>please make an X by those changes</u>

A) vision hearing coordination balance strength speech memory thinking

B) energy sleeping eating elimination menstrual cycle sexual activity

List all medication you are taking:

____

____

____

Have you ever been hospitalized for mental or nervous problems? ____**No** ____**Yes**
If yes, when and where

____

____

Have you ever attempted suicide? ____**No** ____**Yes**
If yes, where and when?

____

____

Are you suicidal now? ____**No** ____**Yes**

How often do you drink alcohol? ____

Have you ever been arrested for driving under the influence (DUI)? ____**No** ____**Yes**
If yes, how many times?
____

Do you use drugs? ____**No** ____**Yes**
If yes, what drugs do you use and how often?

____

____

Have you ever been arrested? ____**No** ____**Yes**
If yes, how many times and for what?

____

____

Are you currently involved or do you expect to be involved in any court related matters?

____**No** ____**Yes**

If yes, please describe

____

____

____

Have your ever been physically, sexually, emotionally abused (Circle to indicate which ones)?

____**No** ____**Yes** If yes, briefly describe: _______________________________________

____

____

What is going on in your life, your marriage or family that brings you to counseling at this time?

____

____

____

What important things about you, your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

____

____

____

Would you like spirituality included in your counseling process? ____**No** ____**Yes**

____

____

____

List any other counseling you or a member of your family are receiving or have received:

____

____

____

What other things are stressful in your life right now?

____

____

____

Client Signature _____________________________________ **Date** __________________

FOR THERAPIST USE:

____

____

Therapist Signature:

____ **Date:** ___________________