Crain Counseling New Client Packet (Adult)

Client Name: _____
Last First MI (preferred name)

Please describe why you are seeking counseling

_____
_____
_____

How long has this been a problem for you? _____

How have you tried to solve this problem? _____
_____
_____

In a few words, please describe your talents, abilities and interests.

_____
_____

Support System

What are the significant relationships in your life? Who do you look to for support?

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Community Supports

Do you currently attend a community support group [ ] Yes [ ] No
If yes, which ones (Dates/times) _____
Have you attended a support group in the past? [ ] Yes [ ] No
If yes, which ones (Dates/times)

Emotional
Areas of Personal Concern

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern
1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating

Aggression		Sexual dysfunction		Irritability		Problems at work	
Anorexia		Sexual Trauma		Obsessions/ Compulsions		Self-image	
Binging/purging		Sleep Disturbance		Poor concentration		Low self esteem	
Emotional Trauma		Feeling worthlessness		Post-traumatic stress		Desire to hurt others	
Low energy		Agitation		Self-harm		Suicidal thoughts	
Grief		Appetite change		Weight loss/gain		Marital problems	
Hallucinations		Conduct problems		Social isolation		Family problems	
Hyperactivity		Depressed mood		Substance abuse		Financial problems	
Mood swings		Elevated mood		Fearfulness		Problems with parents	
Oppositional Behavior		Emotionality		Forgetfulness		Parenting problems	
Panic Attacks		Anxiety		Anger		Co-Parenting problems	
Phobias		Guilt / Shame		Legal problems		Child discipline	
Physical Trauma		Hopelessness		Problems at school		Rejection	

Psychiatric and Behavioral Health History

1. Have you seen a counselor before? [ ] Yes [ ] No
2. Please describe who, when, what for: _____

3. Are you currently seeing a counselor? [ ] Yes [ ] No
4. Are you currently under treatment of a psychiatrist? [ ] Yes [ ] No
5. Are you currently prescribed any psychiatric medications? [ ] Yes [ ] No
6. Please list psychiatric medications: _____
   _____

7. Please list past psychiatric medications: _____
   _____

8. Have you ever been hospitalized due to a mental health condition? [ ] Yes [ ] No
9. If yes, please list dates, hospitals, and reasons: _____
   _____

10. Have you self-harmed in the last month? [ ] Yes [ ] No
11. Where and how?_____

12. Have you taken steps toward taking your own life in the past month? [ ] Yes [ ] No
13. When?_____

14. Have you ever attempted suicide? [ ] Yes [ ] No
15. When?_____

16. Do you have a family history of mental health concerns? [ ] Yes [ ] No
17. Briefly explain: _____
    _____

Trauma History

1. Have you experienced physical abuse? [ ] Yes [ ] No
2. Have you experienced emotional abuse? [ ] Yes [ ] No
3. Have you experienced sexual abuse? [ ] Yes [ ] No
4. Have you experienced a sexual assault? [ ] Yes [ ] No
5. If yes to any of the above please briefly explain: _____
   _____

6. Have you lost a significant friend or family member to death in the last year? [ ] Yes [ ] No
7. Have you witnessed someone die? [ ] Yes [ ] No
8. Have you been in a car accident or major accident within the last year? [ ] Yes [ ] No
9. Have you ever had a gun or weapon pointed/used on you? [ ] Yes [ ] No
10. Have you ever witnessed someone threatened/ harmed with a gun, knife or other weapon? [ ] Yes [ ] No
11. Have you ever lived in a war zone? [ ] Yes [ ] No
12. Have you ever been kidnaped or held against your will? [ ] Yes [ ] No

Substance Use History

Drug	First Use: age/year	Last time using	Frequency
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Pain killers			
Inhalants			
Cocaine			
Heroine			
Ecstasy			
Ice/Crystal Meth			
Amphetamines/ Speed			
Hallucinogens (LSD)			
Crack Cocaine			
PCP			
Other:			

1. Do you have a history of alcohol abuse? [ ] Yes [ ] No
2. At what age did drinking become a regular pattern in your life? _____
3. Do you experience intoxication 2 or more times a week? [ ] Yes [ ] No
4. Do you feel your drinking is a problem in your life? [ ] Yes [ ] No
5. Have you ever had a DUI? [ ] Yes [ ] No
6. If yes when: _____
7. Do you have a history of drug abuse? [ ] Yes [ ] No
8. Have you used illegal drugs in the last year [ ] Yes [ ] No
9. Have you abused prescription medication in the last year [ ] Yes [ ] No
10. Have you ever been arrested for illegal drugs? [ ] Yes [ ] No
11. Have you ever been in treatment for drug or alcohol use? [ ] Yes [ ] No
12. Does your family have a history of alcohol abuse? [ ] Yes [ ] No
13. Does your family have a history of drug abuse? [ ] No [ ] father [ ] mother [ ] grandparents [ ] other

Medical History
Medical or Physical Concerns

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern
1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating

	Headaches		Muscle Tension		Mental Illness
	Sleeplessness		Nausea		Gynecological Problems
	Too Much Sleep		Constipation		Recent Weight Gain
	Breathing Difficulty		Diarrhea		Recent Weight Loss
	Chest Pain		Vomiting		ADHD
	Blurred Vision		Chronic Pain		Nightmares/sleepwalking
	Fatigue		Dizziness		Chronic illness
	Unable to Relax		Feeling Panicky		Difficulty Concentrating
	Poor appetite		Stomach trouble		Sexual dysfunction
	Self-harm		Binging		Purging

Medical or Physical Concerns

Please Mark All That Apply to You or your Family History					
Self	**Family History**		**Self**	**Family History**	
		Hyper/Hypo Thyroid			Anxiety Disorder
		Alcoholism			Depression
		Heart Disease			Manic Depression
		Arthritis			Schizophrenia
		Asthma			Hyperactivity
		Diabetes			Chemical Addiction
		Cancer			Gambling Addiction
		Seizures			Sexual Dysfunction
		High Blood Pressure			Sexual Addiction
		Birth defects			Alzheimer's/ dementia
		Stroke			Intellectual disability

Physician Name: _____
Physician Phone number: _____
Last known wellness visit: _____
Please list all current medications and reasons for use: _____
_____
Please list all known allergies: _____
_____

Please describe any serious hospitalizations: _____
_____
How often do you exercise in a week? _____

<u>Sexual Development:</u>

Age at first sexual experience _____

Time marked by perspicuity _____

First pregnancy/fatherhood _____

Sexually active [ ] Yes [ ] No Unsafe sex [ ] Yes [ ] No History [ ] Yes [ ] No

Have you experienced an abortion [ ] Yes [ ] No

If yes when: _____

Sexual Orientation: [ ] Straight [ ] Gay [ ] Lesbian [ ] Bisexual [ ] Transgender [ ] Other _____

Sexual Identity: [ ] Male [ ] Female [ ] Other _____

Family History
Family of Origin

Father's Name: _____ DOB/Age: _____ / _____

[ ] Biological Parent [ ] Adopted parent [ ] Foster Parent
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA

Describe his personality: _____
How did he show love? _____
Describe your relationship: _____
_____

Mother's Name: _____DOB/Age: _____ / _____
[ ] Biological Parent [ ] Adopted parent [ ] Foster Parent
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA

Describe her personality: _____
How did she show love? _____
Describe your relationship: _____
_____

Describe your parents' relationship: _____
_____

What did discipline look like growing up:

[ ] Parents are married to each other
[ ] Parents are separated _____ Years
[ ] Parents are divorced ____ Years
[ ] Mother remarried _____ Times
[ ] Father remarried _____ times
[ ] Mother deceased _____ Years
[ ] Father deceased _____ Years

[ ] Mother incarcerated ____ Years
[ ] Father incarcerated __ Year

Step-father's Name: _____ DOB/Age: _____ / _____
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA
Describe his personality: _____
How did he show love? _____
Describe your relationship: _____
_____

Step-mother's Name: _____DOB/Age: _____ /_____
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA
Describe her personality: _____
How did she show love? _____
Describe your relationship: _____

Brothers and Sisters

Name	Living	Age
	[ ] yes [ ] no	
	[ ] yes [ ] no	
	[ ] yes [ ] no	
	[ ] yes [ ] no	
	[ ] yes [ ] no	
	[ ] yes [ ] no	

Was favoritism shown to you or specific siblings? Explain. _____

_____

_____

Immediate Family

Marital Status

[ ] Single, never married [ ] Separated [ ] Widowed
[ ] Engaged [ ] Divorced [ ] Remarried
[ ] Married [ ] Live in Relationship

Relationship satisfaction

[ ] Very satisfied [ ] Satisfied [ ] Somewhat satisfied [ ] Dissatisfied [ ] Very Dissatisfied

Describe concerns related to your intimate relationship: _____

_____

_____

Children

Name: _____ Age: _____ Sex: _____ [ ] biological [ ] adopted [ ] step child [ ] foster care

Name: _____ Age: _____ Sex: _____ [ ] biological [ ] adopted [ ] step child [ ] foster care

Name: _____ Age: _____ Sex: _____ [ ] biological [ ] adopted [ ] step child [ ] foster care

Name: _____ Age: _____ Sex: _____ [ ] biological [ ] adopted [ ] step child [ ] foster care

Please describe any concerns related to your children or parenting: _____

_____

Spirituality and Religion

Do you believe in God? [ ] Yes [ ] No
Do you believe spirituality or religion to have a positive influence on your life? [ ] Yes [ ] No
Do you attend church? [ ] Yes [ ] No
Do you use prayer in your life ? [ ] Yes [ ] No
Is spirituality important to you? [ ] Yes [ ] No
Is spiritual growth important to you?

Please describe your relationship with spirituality, religion, or faith: _____

_____

Socio-Economic History

Living situation

[ ] Rent apartment [ ] Rent house [ ] Own home [ ] Staying with friends/ family
[ ] facing foreclosure [ ] Facing Eviction [ ] Homeless [ ] Other

Who resides with you: _____

Do you feel your residence is safe? [ ] Yes [ ] No

Education

Highest level of education: [ ] Some high school [ ] High School [ ] GED [ ] College
[ ] vocational school [ ] Graduate school/ doctorate

Were you active in high school [ ] Yes [ ] No

How would you best describe your experience in school? (check all that apply)

[ ] Easy [ ] Moderately challenging [ ] Difficult [ ] socially hard [ ] indifferent [ ] rewarding [ ] a waste of time

Employment

[ ] Employed [ ] Unemployed Employer/last employer: _____

How long have you had this position? _____

Financial

I have enough finances to cover my needs [ ] Yes [ ] No
I have enough finances to cover the needs of my family [ ] Yes [ ] No

Social supports

It is difficult for me to form and maintain relationships [ ] Yes [ ] No
I can identify a group of close friends in my life [ ] Yes [ ] No
My closest relationships are market by times of drinking or doing drugs together [ ] Yes [ ] No
I tend to isolate from people around me [ ] Yes [ ] No
It is difficult for me to make close friends [ ] Yes [ ] No
I participate in activities that bring me enjoyment [ ] Yes [ ] No

Culture

The cultural identify I associate with is: _____
The Ethnicity I associate with is: _____
The Religion I associate with is: _____

Military

I served in the military [ ] Yes [ ] No
If yes. Which branch [ ] Army [ ] Airforce [ ]Navy [ ] Marines [ ] Cost Guard [ ] Reserves [ ] Other
While in the military I received a Non-judicial punishment [ ] Yes [ ] No
While in the military I spent time in an active War zone [ ] Yes [ ] No
I have been treated for PTSD as a result of my time in the military [ ] Yes [ ] No

Legal

I have been arrested [ ] Yes [ ] No
I have spent time in Jail [ ] Yes [ ] No
I have been legally charged for crimes [ ] Yes [ ] No
I have been convicted for crimes [ ] Yes [ ] No
I am currently facing legal involvement [ ] Yes [ ] No