Clinical History Form

FRIEDMAN
Counseling Services, LLC

Full Name _____ **Date of Birth (XX/XX/XXXX)** _____

FOR YOUR THERAPIST

What type of counseling are you seeking at this time?

- ☐ Individual Counseling
- ☐ Pre-Marital Counseling
- ☐ Couple's Counseling
- ☐ Co-Parent Counseling
- ☐ Family Counseling

Have you previously participated, or are you currently participating, in any of the following? *(select all that apply)*

- ☐ Individual Counseling
- ☐ Couple's Counseling
- ☐ Family Counseling
- ☐ Other Counseling

If you selected any of the above, please describe when and for what purpose you sought these counseling services?

YOUR CURRENT INFO

Age _____

Education Level *(select all that apply)*

- ☐ High School Diploma or GED
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate
- ☐ Other: _____

Employment

- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Other: _____

Briefly describe your work _____

Relationship Status

- ☐ Single
- ☐ Dating
- ☐ Considering a long-term commitment
- ☐ Committed
- ☐ Considering separation and/or divorce
- ☐ Other: _____

Living Arrangement

- ☐ I live alone.
- ☐ I live with others *(list first names and relationship of other household members to you in space below)*

MEDICAL HISTORY

Please provide information about any illnesses, surgeries, injuries, hospitalizations, or medical treatments that have impacted, or continue to impact, you? If none, please indicate that here.

Have you been hospitalized or participated in a partial-hospitalization program for a mental health concern? If so, please provide dates and a description here.

Do you have any allergies to medications? If yes, please list here.

Do you take prescription medications and/or supplements? If yes, please list here.

If taking prescription medication(s), who is your prescribing healthcare provider?

Name _____

Area of Practice (psychiatry, pediatrics, family) _____

SUBSTANCE USE INFO

Do you drink alcohol? If yes, please provide days/drinks per week.

Do you use tobacco or nicotine products? If yes, please describe.

Do you use recreational substances? If yes, please describe.

Have you ever participated in outpatient and/or in-patient treatment for alcohol or substance use? If yes, please describe.

TRAUMA HISTORY

Have you been impacted directly and/or indirectly by the following? *(select all that apply)*

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse

If you feel comfortable, please briefly provide more info here.

CURRENT SYMPTOMS

Are you currently experiencing, or have you experienced, any of the following? *(select all that apply)*

- ☐ Headaches
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ Sexual Dysfunction
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Other: _____

Are you currently experiencing, or have you experienced within the last six months, any of the following? *(select all that apply)*

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue/low energy
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful or crying spells
- ☐ Hopelessness
- ☐ Fear
- ☐ Anxiety
- ☐ Panic
- ☐ Guilt
- ☐ Irritability
- ☐ Aggressivity
- ☐ Hyperactivity
- ☐ Mood Swings
- ☐ Agitation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Intrusive Thoughts
- ☐ Compulsive Behaviors
- ☐ Other: _____

Do you engage, or have you engaged, in self-harming behaviors?

- ☐ No
- ☐ Yes *(if comfortable, please provide more info here)*
- ☐ In the past, but not currently *(if comfortable, please provide more info here)*

Do you have suicidal thoughts?

- ☐ No
- ☐ Yes *(if comfortable, please provide more info here)*

Have you attempted suicide?

- ☐ No
- ☐ Yes *(if comfortable, please provide more info here)*

Do you have thoughts or urges related to harming others?

- ☐ No
- ☐ Yes *(if comfortable, please provide more info here)*

CONSENT TO SHARING INFORMATION

I consent to sharing the information provided here with Friedman Counseling Services, LLC.

Signature: _____ Today's Date: _____