LifeChange Counseling and Psychological Services

Client Name: ____ Date of Birth: ______________ Age_________

Address:____ Email:____________________________________

City, State, Zip:____ Preferred Phone:_________________________

HISTORY OF PRESENT PROBLEM

Describe the primary reasons you are seeking services from LifeChange Counseling and Psychological Services. Tell us your main problem, how long this has been a problem, and how it is affecting you today.

____

____

____

MEDICAL HISTORY - MENTAL HEALTH

☐ Check here if you have never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		**Effectiveness** of Medications

Have you had times when you were having suicidal thoughts? ☐Yes ☐No Thoughts of harming others? ☐Yes ☐No

Please describe these thoughts and/or behaviors: ____

____

____

What seems to have helped you make the most improvement during your past mental health treatment?

____

____

____

Have any family members had mental health or substance abuse problems? ☐Yes ☐No

If YES, state their family relationship to you and what problem they had.

____

____

TRAUMA-ABUSE HISTORY

Has there ever been a time in your life when you were traumatized or abused? ☐ yes ☐ no
If yes, was it: ☐ physical ☐ sexual ☐ emotional ☐ mental ☐ other trauma

Please describe the trauma-abuse: ______________________________________

____

____

How do you think this affects you today? ______________________________

____

MEDICAL HISTORY – PHYSICAL HEALTH

A. Primary Care Provider Name:

B. List Health Issues	Have Now	Had in Past	Family Has		Have Now	Had in Past	Family Has
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

C. Treatment History

What **prescription** medications are you currently taking? (non-psychiatric)

What **non-prescription** medications are you currently taking?

MEDICAL HISTORY – SUBSTANCE USE

A. Impact of Substances

☐ NO to ALL

During the last 12 months -

	YES	NO
• Did you use larger amounts of alcohol/drugs, or use them for a longer time than you had intended?	☐	☐
• Did you try to cut down on your alcohol or drug use but were unable to do it?	☐	☐
• Did you spend a lot of time getting alcohol or drugs, using them, or recovering from their use?	☐	☐
• Did you get so high or sick from alcohol or drugs that it -		
• kept you from doing work, going to school, or caring for children?	☐	☐
• caused an accident or put you or others in danger?	☐	☐
• Did you spend less time at work, school, or with friends so that you could use alcohol or drugs?	☐	☐
• Did your alcohol or drug use cause-		
• emotional or psychological problems?	☐	☐
• problems with family, friends, work, or police?	☐	☐
• physical health or medical problems?	☐	☐
• Did you increase the amount of alcohol/drug you were taking to get the same effects as before?	☐	☐
• Did you ever keep taking a drug or alcohol to avoid withdrawal or keep from getting sick?	☐	☐
• Do you get sick or have withdrawal when you quit or missed taking a drug or alcohol?	☐	☐

B. Treatment Readiness

- What treatment have you had for Alcohol/Drug related problems?
  ☐ none ☐ AA/NA ☐ outpatient treatment ☐ residential treatment ☐ detoxification ☐ hospitalization
- How many times have you been in a drug or alcohol treatment program (do not count AA/NA)?
  ☐ never ☐ one ☐ two ☐ three ☐ four or more
- How serious do you think your problem with alcohol or drugs is?
  ☐ not serious ☐ mildly ☐ moderately ☐ significantly ☐ extremely
- How important is it for you to get drug or alcohol treatment now?
  ☐ not important ☐ mildly ☐ moderately ☐ significantly ☐ extremely

C. Substances Used

CATEGORY	AGE STARTED	AGE STOPPED OR CURRENT	AVERAGE FREQUENCY IN PAST YEAR	AVERAGE AMOUNT USED EACH TIME	COMMENTS
ALCOHOL (beer, wine, liquor)					
CAFFEINE (coffee, tea, soda, "No-Doze," etc.)					
NICOTINE (cigarettes, chew, snuff, cigars)					
STIMULANTS (cocaine, crack, crank, speed, amphetamines, ephedrine, methamphetamine)					
CANNABIS (marijuana, hashish, hash oil)					
SEDATIVE HYPNOTICS (barbiturates, ie, Seconal, Phenobarbital; benzodiazepines, ie, Valium, Xanax, sleeping pills; Quaalude, Doriden)					
HALLUCINOGENS (LSD, PCP, mushrooms, ketamine, ecstacy, MDMA)					
INHALANTS (glue, paint, solvents, rush, gasoline, white out)					
OPIOIDS (hydrocodone, oxycodone, opium, morphine, heroin, codeine, methadone)					
OTHER (dextromethorphan, steroids, etc.)					

FAMILY BACKGROUND

Who were you raised by? ☐ parents ☐ parent/step-parent ☐ single parent ☐ Other ________________________

What do you think about your upbringing? ____

____

What kind of relationship do you have today with those who raised you? _____________________________________

How many brothers or sisters do you have? ____

What is your relationship like with your brothers and sisters? ____

What problems did you have as a child or adolescent? (mental health, drug/alcohol, neglect, abuse, etc.)

____

PEERS AND SIGNIFICANT RELATIONSHIPS HISTORY

Sexual Orientation: ☐ heterosexual ☐ homosexual ☐ bisexual ☐ uncertain

Marital Status: ☐ never married ☐ married ☐ divorced ☐ separated ☐ widow(er) ☐ living as married

How many times have you been married?_____ How long each time?_______________________________________

Spouse Name: ____ Age: ____________

Total number of children: ___his ___hers ___ours. If children live with you, please give:

Name: _______________________________ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _______________________________ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _______________________________ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _______________________________ Age___ Sex___ ☐ his ☐ hers ☐ ours

Who do you live with? ____

What problems exist in your current intimate relationship? ____

What problems are related to your children? ____

How many close friends do you have? _______ How well do you get along with others? _________________

What organizations, clubs or teams do you belong to? ____

SCHOOL - EDUCATIONAL HISTORY

What is the last grade you **completed**? ☐6th or less ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th ☐ GED
College: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ masters ☐ doctorate

What specialized or technical training do you have (i.e., cosmetology, welding, etc.)? ___________________________

Are you currently pursuing your education? ☐ yes ☐ no What field of study? _________________________

What was your average grade during your last three years of schooling? ☐ A ☐ B ☐ C ☐ D ☐ F

What problems with learning did you have? ____

Did you have testing to assess for learning disabilities or ADHD problems? ___________________________________

Were you in resource or special education classrooms? ___________________________________

How well did you get along with teachers? ___________________________________

EMPLOYMENT and FINANCES HISTORY

Are you currently: ☐ employed ☐ unemployed ☐ laid off ☐ on disability How long?____________________

Where did you last work (or currently work)? ___________________________________

What was/is your position there? ___________________________________

Where did you work the longest? ______________________________ How long? ________________

How many jobs have you had in the last 5 years? ___________________________________

What problems have you had on the job? ___________________________________

What problems related to finances do you have? ___________________________________

LEGAL HISTORY

Have you ever been arrested or taken to court? ☐ yes ☐ no
Have you ever been placed in a correctional institution? ☐ yes ☐ no When? ________ How Long? ____________

What have you been arrested for as a juvenile? ___________________________________

What have you been arrested for as an adult? ___________________________________

What legal issues or problems do you have right now? ___________________________________

SPIRITUAL BACKGROUND

What religion do you identify with?
☐ none ☐ Christianity ☐ Judaism ☐ Islam ☐ Buddhism ☐ Taoism ☐ Other: ________________________

Do you consider yourself a “spiritual” person? ☐ yes ☐ no
Are you a member of a local religious group? ☐ yes ☐ no Which one? ________________________________
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

What problems have you had regarding spiritual issues? ___________________________________

How might your faith/spirituality help you overcome your problems? ______________________________

SIGNIFICANT LIFE EVENTS

Please take some time to think of the most significant life events that have happened to you. These should be events that are either positive or negative, but have been important in shaping who you are today. Briefly list up to 10 of the most important events:

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

THANK YOU!

PLEASE SEND THIS COMPLETED FORM BEFORE YOUR FIRST APPOINTMENT TO:

LifeChangeCPS@gmail.com

DrDurham@LifeChangeCPS.com