



The Northwest Catholic Counseling Center

Serving all regardless of faith or finances

Adult Psychosocial History

Date _____

Client ID _____
(office use only)

Please provide the following information. It will assist us in getting to know you and your concerns. It will be held to the same standards of confidentiality as an appointment.

Name _____
First M.I. Last

Address _____

_____ City State Zip

Birth date ____/____/____

<p>Home Phone: _____</p> <p><i>May we leave a message?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Do you prefer calling for appointment reminders?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cell Phone: _____</p> <p><i>May we leave a message?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Do you prefer texting for appointment reminders?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Email: _____</p> <p><i>May we email you?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Do you prefer emailing for appointment reminders?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--

Relationship Status: Single Married Partnered Separated Divorced Widowed

Gender: Female Male Transgender Other Pronouns: _____

Emergency contact-please list the name, telephone number and relationship _____

Referred by _____

We would like to periodically send you newsletters and other information regarding the Center and its activities. Please check if you do not want to receive this information.

Disability

Defined as substantially limiting movement, sensory, social, employment, or learning activities.

Yes No _____

Ethnicity (Choose all that apply)

- American Indian or Alaska Native Asian Black or African American
- Hispanic or Latino Native Hawaiian or Pacific Islander White
- Multi-Ethnic _____
- Other _____
- Prefer not to answer

Social Information

Please describe your primary support system (family, friends, support groups, church community, etc)

Do you identify as LGBTQ? Yes No

Education/Occupation Information:

Are you currently employed? Yes No

If yes, name of current employer/position :

Please indicate highest level of education:

Degree, if applicable:

Are you happy in your current position?

Please list any work-related stressors :

If unemployed, how long have you been unemployed?

Religious/Spiritual Information:

Do you consider yourself to be a religious person? Yes No

Do you consider yourself to be a spiritual person? Yes No

If yes, what is your faith/religious/spiritual path?

Office Use Only		
Entered in FM	Entered in TH	Scanned

Legal History

Are you currently or have you ever been involved in any legal proceedings (SSD, traffic, divorce, civil, criminal)?

If yes, please describe _____

Are you preparing for any legal proceedings? Yes No If yes, please explain _____

Are you presently on probation or parole? Yes No If yes, please explain _____

Mental Health History

Are you currently receiving any mental health treatment or prescribing services elsewhere?

Counseling: Name of counselor/agency: _____

Medications: Name of Prescriber: _____

Have you had previous counseling? Yes No

If yes, previous therapist's name:

How long ago did you receive these services?

Have you ever engaged in self-harming behavior? Yes No

Describe when and the last time:

Have you ever attempted suicide: Yes No When:

Were you hospitalized for either self-harm or for an attempted suicide in the past? Yes No

What hospital: _____

In the last year, have you experienced any significant life changes or stressors (death of a loved one, divorce, loss of job, etc.)?

Have you experienced any traumatic events?

What coping strategies do you currently use and how effective are they?

What are your goals or concerns for therapy?

What do you consider to be your strengths? _____

Family Mental Health History

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? **Check any that apply and list family member** (sibling, parent, uncle, etc).

- Depression _____
- Anxiety _____
- Schizophrenia _____
- Eating Disorder _____
- Trauma _____
- Bipolar Disorder _____
- Panic Attacks _____
- Alcohol/Substance Abuse _____
- Completed Suicides _____
- ADHD _____

Health Information

Allergies: (List any meds, foods, etc.)

How would you describe your physical health at present?

Poor Unsatisfactory Satisfactory Good Very Good

Primary Care Provider _____ Phone # _____

Date of last physical: _____

Please indicate if you experience now or in your history any of the following medical issues:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Pregnancy Issues
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> Migraines	<input type="checkbox"/> Binging/purging/food restriction
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Premenstrual issues	<input type="checkbox"/> Unexplained weight fluctuations

Have you ever been hospitalized for any of these conditions and when:

Name: _____

Please list all medications (including over-the counter/herbal remedies) and dosages.

Meds	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What do you do for physical activity:

Substance Use

Do you use tobacco? Yes No How much per day: _____

Do you use Caffeine? Yes No How much per day: _____

Do you drink alcohol? Yes No How much per week: _____

Do you engage in recreational/street drugs? Daily Weekly Monthly Rarely Never

What kind?

Describe any history with recreational/street drugs:

If applicable, describe any treatment obtained for addiction:

Please check behaviors and symptoms that happen more often than you would like them to occur.

- | | |
|---|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Mood shifts |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Concentration issues | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Persistent urges or thoughts |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Physical discomfort |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Pornography concerns |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Reckless or self-destructive |
| <input type="checkbox"/> Excessive purchasing | <input type="checkbox"/> Repetitive behaviors |
| <input type="checkbox"/> Exposure to traumatic event(s) | <input type="checkbox"/> Restless or keyed up |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Revengeful |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Gambling concerns | <input type="checkbox"/> Sexual addictions |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Shame/Guilt |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Socially avoidant or isolating |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Stomachaches |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Isolating from friends/family | <input type="checkbox"/> Suspicious of others |
| <input type="checkbox"/> Jealousy | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Worrying excessively |
| <input type="checkbox"/> Memory impairment | |
| <input type="checkbox"/> Inadequacy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Insecurity | |
| <input type="checkbox"/> Irritability | |