Laura Pryor
mental health therapist

Client Information

Name: _____

Home Address:_____

Home Phone:_____ Work Phone: _____ Cell:_____

Date of Birth: _____ Name you prefer to go by: _____

Employer & Occupation: _____

Other Household Members (names and ages):

_____ _____

_____ _____

_____ _____

Emergency Contact (name, relationship, and phone number):

_____

_____

Who referred you to us? _____

Primary Care Physician: _____

Phone Number: _____ Address:_____

Medical Information (list any illnesses, injuries, conditions, drug allergies):

_____ _____

_____ _____

_____ _____

Medications (name and dosage):

_____ _____

_____ _____

_____ _____

A. Presenting Problem

What happened to bring you in today? (Symptoms, onset, duration, intensity, degree of impairment):

_____

_____

_____

_____

_____

_____

_____

_____

B. Work/School/Military History:

Employed? ❒ Yes ❒ No

Where?:_____

Title:_____How Long?_____

Any problems at work that are related to your alcohol/drug use (lateness, hangovers, absenteeism, etc)?

What is your highest level of education?

Have you experienced any learning difficulties in an educational setting?

Future education goals?

Did you serve in the military? ❒ Yes ❒ No Branch and rank?_____

When and how were you discharged?_____

Did you serve in war zones, or experience any major trauma? ❒ Yes ❒ No

C. Alcohol/Drug Information:

Chemical	What age did you start using? How did you use it (snort/smoke/IV)?	How much? How did it progress?	When was the last time you used this substance?	What was the longest period of sobriety?
Alcohol				
Marijuana				
Prescription meds other than how they were prescribed?				
OTC used to get high				
Cocaine/Crack				
Amphetamines				
Heroin				
Caffeine				
Other/Tobacco				

C. Alcohol/Drug Information (continued):

Have you ever experienced a blackout? ❒ Yes ❒ No

Do you need to use more or less to get the same effect you used to? ❒ Yes ❒ No

When you quit using alcohol/drugs have you ever experienced physical/emotional discomfort? ❒ Yes ❒ No

What is the average **monthly** you would spend on alcohol/drugs? $_____

Have you ever used prescription medicine other than as prescribed or obtained it illegally? ❒ Yes ❒ No

Do you think you have a problem with alcohol or drugs? ❒ Yes ❒ No

Describe your pattern of use during your worst year:

_____

_____

What have been some of the negative consequences from your alcohol/drug use?

Family_____

Employment_____

Financial_____

Physical Health_____

Social Relationships_____

List all of the blood-related relatives that have had what you call an alcohol/drug problem:

_____

_____

Have you been in treatment before? If so, when?

Gambling

Have you ever bet more money than you intended? ❒ Yes ❒ No

Do you think you have a problem with gambling? ❒ Yes ❒ No

Have you been told by others you have a problem with gambling? ❒ Yes ❒ No

D. Legal History:

List all previous arrests, detentions, and/or convictions you have received:

_____

_____

E. Family information: Marriages, children, patterns, etc.

With whom do you live with? _____

Do they drink or use? ❒ Yes ❒ No What?_____

Were you raised by your biological parents? ❒ Yes ❒ No Are they divorced? ❒ Yes ❒ No

When did they divorce and why? _____

Describe your relationship with your parents? _____

_____

_____

How many siblings do you have? _____

Name of siblings	Age	Relationship facts

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Are you married? If so, to whom? _____

List any previous marriages or significant relationships: _____

_____

How many children do you have?_____ What is your parenting style?: _____

_____

Have you ever been involved with Child Protective Services? If so, please provide details:

_____

_____

_____

Children (biological and non-biological):

Name	Age	Name of father/mother

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Who are your social supports?

_____

_____

_____

_____

What do you do for leisure/fun?

_____

_____

Describe three personal strengths:

_____

_____

_____

Describe three personal challenges:

_____

_____

_____

What significant losses have you experienced in your life?

_____

_____

_____

_____

F. Psychiatric/Behavioral History

Do you have any of these in your history?

Suicidal thoughts ever in your life? ❒ Yes ❒ No
Are you having these thoughts now? ❒ Yes ❒ No
Do you have a plan? ❒ Yes ❒ No
Do you have a way to carry it out? ❒ Yes ❒ No
Do you have access to weapons (gun, knife, etc)? ❒ Yes ❒ No
Suicide attempts? ❒ Yes ❒ No
Homicidal thoughts? ❒ Yes ❒ No
Depression? ❒ Yes ❒ No
Previous mental health diagnoses and/or hospitalizations, and family history? ❒ Yes ❒ No
Teen pregnancy? ❒ Yes ❒ No
Emotional/physical/sexual/neglect abuse? ❒ Yes ❒ No
Developmental History Milestones Met ❒early ❒late ❒normal

_____

Peri-natal History (details of labor/delivery):

_____

_____

Pre-natal History (medical problems during pregnancy, mother's use of medications):

_____

_____

Running away from home as a teen? ❒ Yes ❒ No
Gang involvement? ❒ Yes ❒ No
Traumatic events experienced in your life (natural disasters, war, abuse, witnessing something like a murder, car accident, 911, etc)? ❒ Yes ❒ No
Abortions? ❒ Yes ❒ No
Affairs? ❒ Yes ❒ No
Frequent change of sex partners? ❒ Yes ❒ No
Sexually transmitted diseases? ❒ Yes ❒ No
Sexual orientation? _____

G. Significant Life Events History

Have you experienced these symptoms/thoughts/behaviors in the past 30 days?

Suicidal thoughts

Increased or decreased appetite (circle one)

Nightmares

Depressed mood

Anxiety

Flashbacks

Short attention span

Anxiety attacks

Suicide attempt

Changes in sleep pattern

Angry outbursts

Inpatient/hospitalizations

Memory impairment

Intrusive thoughts

Self-harming behavior (picking, burning, cutting the skin)

Dissociative episodes

Racing thoughts

Panic attacks

Anxiety attacks

Impairments in work/academic/home functioning

Dizziness/vertigo

Please check the following statements that apply to you/your childhood:

Your parents or guardians were separated or divorced

You live(d) with a household member who served time in jail or prison

You live(d) with a household member who was depressed, mentally ill, or attempted suicide

A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you feel afraid that you might be physically hurt

Someone touched your private parts or asked you to touch their private parts in a sexual way

More than once, you went without food, clothing, or a place to live, or had no one to protect you

Someone pushed, grabbed, slapped, or threw something at you OR you were hit so hard you were injured or had marks

You were in foster care

You experienced harassment or bullying at school

You lived with a parent or guardian who died

You were separated from a primary caregiver through deportation or immigration

You or another household member had a serious medical procedure(s) or life-threatening illness

You often saw or heard violence in the neighborhood or in the school neighborhood

You were often treated badly because of race, sexual orientation, place of birth, disability, or religion

Total Checkmarks: _____


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