



Counseling Solutions Inc.
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Client History Form (Adult)
(Please Print)

Today's Date: _____

Name: _____

Date of Birth (DOB): _____

Reason for Consultation:

Duration of Problem(s):

Less than 3 Months 3-11 Months 1-2 years More than 2 years

General Information:

Occupation: _____

Employer: _____

How long have you been in this job? _____

If you have not been in this job for 5 years, please complete the table below:

Job	Start Date	End Date	Reason for Leaving

Education: High School Associates Bachelors Graduate Post-Graduate

Military Service: Yes, but currently inactive Yes & currently active No

If yes, branch of service and length in service _____

Have you ever had any legal problems? _____ If yes, explain:

Religious Affiliation (if any): _____

Marital Status: Single Married Separated Divorced Widowed

Marital History (Leave Blank if Never Married):

Dates of Marriage	Spouse's Name	How did marriage end?	How many children?

Children (Leave Blank if You Do Not Have Children):

Child's Name	Age	Live at Home (Y/N)?

Residents in Home (In addition to children and spouse):

Name of Person	Age	Relationship to You

How long have you lived in this home? _____

Have you recently moved or have plans to move in the near future? _____

Please complete the following table with information regarding your parents/siblings:

Name	Relation	Current Health Status	Occupation	How Often Are You in Contact?	City/State

Have you ever been separated from your current immediate family for prolonged periods of time? _____ If yes, explain: _____

Were there any separations from family when you were a child? _____ If yes, explain:

Recent (In last 5 years) Deaths of Family, Close Friends or Pets:

Relationship to You	Date of Death	Cause of Death

Health and Mental Health Information:

Are there or have there ever been psychiatric problems in your immediate family (mental, emotional, sexual or substance abuse)? _____ If yes, complete the table below:

Family Member	Diagnosis/Issue	Psychiatric Treatment (Y/N)?	Hospitalized (Y/N)?

Is there or has there been any instances of domestic violence (including self)? _____ If yes, complete the table below:

Family Member	Brief Explanation

Have you or an immediate family member ever been hospitalized for a medical reason? _____ If yes, please complete the table below:

Immediate Family Member	Reason for Hospitalization	When?

Please list any medical conditions or disabilities as well as medications associated with these illnesses.

Medical Condition/Disability	Medication	Dosage

Have you ever been pregnant? _____ If yes, please complete the table below:

Your Age	Outcome (Abortion, Miscarriage, Stillborn, Birth, etc.)

Do you drink alcohol? _____ If yes, please complete the table below:

Type of Alcohol	Quantity	Frequency/Week	Any Untoward Effects

Do you use medications or illegal drugs? _____ If yes, please complete the table below:

Type of Drug	Frequency of Use	Reason for Use	Effects