PASSAGES PROGRAM: CLIENT HISTORY

Briefly describe why you are seeking help at this time:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

Have you had outpatient counseling/therapy before for this or other problems? Please give therapist's name, approximate dates of counseling, and if it helped.

Have you had inpatient treatment for emotional/mental health problems? Please state where and when you were treated.

Has anyone in your family had emotional/mental health problems? Please state their relationship to you, e.g. “mother was depressed.”

Please check any of the following that apply to you:

___ thoughts of suicide	___thoughts of harming others	___nervousness/anxiety
___attempts to kill yourself	___feelings of hopelessness	___phobias
___trouble controlling your temper	___violence toward others	___behavior problems
___poor impulse control	___excessive anger	___defiant towards authority
___difficulty concentrating	___loss of appetite	___panic attacks
___trouble getting to sleep	___waking during the night	___waking early each day
___depressed mood	___forgetfulness	___mood swings
___large weight loss/gain	___inability to make decisions	___racing thoughts
___excessive guilt	___hearing voices	___seeing things others don't

___history of physical abuse ___history of sexual abuse ___health problems

___cutting/hurting yourself ___tingling or numbness ___financial problems

___problems at work ___family problems ___legal problems

Health information

List any medical or physical problems and when they were diagnosed:

List any major surgeries (for which you were put to sleep) and dates:

List any serious illnesses or injuries, especially those involving the head:

List any allergies to food or medications:

Date of last physical examination (approximate):________________________________

List all of the prescription and over-the-counter drugs and supplements you are using:

Check substances you use in any amount at all:

		How much do you use per:			
	Age first used	**weekday**	**weekend**	**month**	**last used**
__Beer	____________	_______	_______	_______	_______
__Liquor	____________	_______	_______	_______	_______
__Wine	____________	_______	_______	_______	_______
__Marijuana	____________	_______	_______	_______	_______
__Cocaine/crack	____________	_______	_______	_______	_______
__Methamphetamine	____________	_______	_______	_______	_______
__Heroin	____________	_______	_______	_______	_______
__Barbiturates	____________	_______	_______	_______	_______
__PCP, LSD	____________	_______	_______	_______	_______
__Tobacco, any type	____________	_______	_______	_______	_______
__Other	____________	_______	_______	_______	_______

Have you ever felt like you should cut down on your drug or alcohol use?

Has a friend or relative expressed concerns about your use?

Have you ever felt guilty about your drinking or drug use?

Have you ever had to take a drink or use a drug the next day to steady your nerves?

Are you in recovery for alcoholism or drug use?

Is there a history of problems with drug or alcohol use in your family?

Please add anything important that you want your therapist to know:

____

Client signature

____

Date