CLINICAL HISTORY FORM

Name: _____ Today's Date: ___ / ___ / _____
Sex: ___ Male ___ Female Age: _____ Birth Date: ___ / ___ / _____
Guardian (if applicable): _____
Primary Address: _____ City: _____ Zip: _____
Highest Grade Completed: _____
(School-aged clients): School _____

Stressors (*Please circle if you have problems in the following areas*)

Family Friends Relationships Educational Economic Housing Legal Health
Sleep Nutrition Lack of Exercise Smoking Substance Abuse Lack of Social Activities

Explain any circled items:_____

Treatment and Psychiatric History (*circle Yes or No*)

Have you ever undergone inpatient psychiatric hospitalization? Yes No *If Yes, explain on back.*
Have you ever seen an outpatient therapist? Yes No *If Yes, please describe the experience, the time frame you were in therapy, the therapist's name, and your reason for therapy on the back of this form.*
Are you currently feeling suicidal or are you actively harming yourself (e.g., cutting)? Yes No
Have you ever tried to harm yourself? Yes No
Have you had any history of violent behavior? Yes No
Have you ever been abused (physical, emotional, sexual)? Yes No

Medical and Medication History

List any major medical issues: _____
List any psychiatric medications: _____
Family History of psychiatric issues (such as depression, ADHD, addiction, anxiety):
_____

Developmental, Educational and Social History

Did your mother experience any complications during your birth? Yes No *If Yes, explain on back.*
Please circle any of the following you experienced during childhood:

Parental fighting	Running away from home	Enuresis (bed-wetting)
Tantrums	Fighting	Victim of bullying
Death of parent/caregiver	Parental divorce	School problems

Current marital status (if applicable): __ Married __Divorced __Separated __Single

Symptoms (*Please circle if you have problems in the following areas*)

Difficulty concentrating	Feeling depressed	Phobias/unexplained fears
Anxiety	Sleep issues	Excessive moodiness
Stress	Disturbing thoughts	Manic episodes
Confusion	Memory loss	Nightmares

Other: _____

Spiritual

Although not required, the following question will contribute to your therapist's understanding of you or your child. It is not our intent to impose our doctrinal perspective but to acknowledge that counseling is not value-free and to be sensitive to your beliefs.
Are spiritual issues or resources important to you in treatment? If so, briefly describe: _____

_____