CLINICAL HISTORY FORM

genesis COUNSELING CENTER℠

Name: _____ Today's Date: _____
Guardian (if applicable): _____ Birth Date: _____
Highest Grade Completed: _____ Sex: ☐ Male ☐ Female
(School-aged clients) School: _____ Age: _____

Stressors (*Please place an X 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

Briefly explain any indicated items: _____

Treatment and Psychiatric History (*Place an X next to Yes or No*)

Have you ever undergone inpatient psychiatric hospitalization? ☐ Yes ☐ No *If Yes, explain on next page.*
Have you ever seen an outpatient therapist? ☐ Yes ☐ No *If Yes, please describe briefly the experience, the time frame you were in therapy, the therapist's name, and your reason for therapy on the next page.*

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 next page.*
Please place an X next to 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 place an X 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:

Additional Information: *(Please type extended explanations here.)*