natural resilience

Date: _____

Name: _____

Basic Background Information

❑ I received an informed consent form and was given the opportunity to ask questions.

My marital status

Married ❑ Divorced ❑ Single ❑ Widowed❑ Separated❑ Other❑

Spouse/Partner's First/Last Name: _____

Children (First name, age)

_____

Religious Affiliation _____

Military History_____

Persons living in my home_____

Work Status_____

Education: Highest grade completed _____ Degree: _____ Other:_____

What type of work do you do?_____

Your Counseling History, Needs & Goals

What is your most pressing reason for seeking counseling?

_____

What are your other concerns:

_____

_____

How did you find out about my practice?

Website ❑ Search engine ❑ Psychology today ❑ Friend ❑

Is Counseling required ❑yes ❑no

Please tell me about your previous counseling experiences:

Provider	Where	When	How Long	Useful (y/n)

Are you currently having suicidal thoughts: ❑yes ❑no

If yes, please describe

_____

Have you ever made a suicide attempt? ❑ yes ❑no
If yes, please explain

_____

Has anyone related to you made a suicide attempt or completed suicide ❑yes ❑no
if yes, please explain

_____

Are you currently having homicidal thoughts? ❑yes ❑no
If yes, please explain

_____

Have you or anyone related to you ever attempted a homicide? ❑yes ❑no
If yes, please explain

_____

Do you worry about your safety in your current living situation? ❑yes ❑no
If yes, please explain

_____

Have you ever struck or threatened people or animals or broken things in your home? ❑yes ❑no
If yes, please tell me about it

_____

What are your strengths?

❑Bright	❑Insightful	❑Motivated	❑Active
❑Have self-control	❑Have friends	❑Can calm myself	❑Mostly healthy
❑Can ask for help	❑Keep my boundaries	❑Have moral ethics	❑Can solve problems
❑Can forgive	❑Can express feelings	❑Have enough money to meet my needs	❑Resourceful
❑Sense of humor	❑Compassionate	❑Patient	❑Good listener
❑Stable employment	❑Satisfied with employment	❑Willing to learn new attitudes and behaviors	❑Can accept love and care for others

Your Social History

How often have you been married and for how long?

_____

Is there anything unusual about your childhood that I should know?

_____

Please list significant traumatic events: _____
Please list significant losses: _____

Please list your brothers and sisters and their ages:

_____

Please describe any significant legal history (i.e. arrest, bankruptcy)

_____

_____

Is there anything else significant that you want me to know?

_____

_____

Medical History

Family Physician _____

Date of last physical examination _____

Please check any illness you currently have or have had in the past

❑Diabetes	❑High Blood Pressure	❑Lung Disease	❑Venereal Disease
❑Asthma	❑Low Blood Pressure	❑Cancer	❑Head Injuries
❑Arthritis	❑Heart Disease	❑Kidney Disease	❑Injuries
❑Anemia	❑Tuberculosis	❑Cirrhosis	❑Muscular Disorder
❑Ulcer	❑Colitis	❑Bone Disorder	❑Obesity
❑Seizures	❑Nerve Disorder	❑Anorexia	❑AIDS/HIV
❑Alcohol/Drug Problems	❑Migraines	❑Urinary Tract Infections	❑Headaches
❑Constipation			

Is there any history of depression, mental illness, or alcohol/drug problems in your family of origin? ❑yes ❑no
If yes, please explain

_____

Do you have any history of depression, anxiety, or mental illness? ❑yes ❑no
If yes, please explain

_____

Please tell me about your past hospitalizations (include psychiatric or substance abuse treatment)

Date	Reason	Hospital	Physician

Are you taking any medications now? ❑yes ❑no
If yes, please list below and include any over the counter medicines taken regularly

Medication	Dosage	How often?	Reason for Medication

Do you take supplements or herbs routinely? ❑yes ❑no
If yes, please list below

Supplement/Herb	Dosage	How often?	Reason for use

Have you had any side effects/allergic reactions from taking medication? ❑yes ❑no
If yes, please explain
_____

Please tell me how much caffeine you consume
Estimated daily consumption of coffee or tea _____cups/day
Estimated daily consumption of soda or pop _____ounces/day

Substance Use Information

Do you have a history of IV drug use? ❑yes ❑no
Have you ever felt you needed to cut down on your drinking? ❑yes ❑no
Have people annoyed you by criticizing your drinking? ❑yes ❑no
Have you ever felt guilty about drinking? ❑yes ❑no
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover ❑yes ❑no
Do you drink socially? ❑yes ❑no How often_____ How much_____
How old were you when you took your first drink?_____
Have you ever attended ❑ A.A. ❑Alanon ❑N.A.
Have you ever had a D.U.I? ❑yes ❑no If yes, how many_____
Have you ever been arrested for a drinking or drug-related offense of any kind? ❑yes ❑no
If yes, please explain_____
_____