Alegre Counseling and Consulting Services, LLC
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CLIENT INTAKE AND FAMILY BACKGROUND HISTORY

DATE:_____ FULL NAME: _____DOB:_____

SOCIAL SECURITY #: _____INSURANCE / MEMBER ID #:_____

PRESENTING PROBLEM

Describe the presenting problem, why you think it's happening, and how long it's been occurring:_____

Please indicate the symptoms you've been experiencing as a result of the presenting problem(s). Please use the following scale:

Severity Scale: *1= Mild 2=Moderate 3=Severe*
Duration Rating: *1 = Less than 1 month 2 = 1-6 mos. 3 = 7-12 mos. 4 = More than 1 year*

REACTION	SEVERITY	DURATION	REACTION	SEVERITY	DURATION	REACTION	SEVERITY	DURATION
Agitated			Crushed			Disturbed Appetite		
Angry			Threatened			Very Energized		
Anxious			Fatigued			Homicidal Thoughts		
Bored			Abandoned			Self-Isolation		
Depressed			Confused			Disturbed Sleep		
Sad			Afraid			Poor concentration		
Helpless			Loved			Sexual Problems		
Betrayed			Moody			Suicidal Thoughts		
Shocked			Hopeless			Obsessed		

What happened that made you decide to come in now?_____

CLIENT: _____ **DOB:**_____**SOCIAL SECURITY #:** _____

Describe in detail when and how you have tried to resolve these issues and the results of those efforts? _____

_____

_____

_____

_____

What do you want to accomplish by coming to therapy?_____

_____

_____

_____

_____

What is your religion?_____What is your cultural background?_____

Is religion or cultural issues affecting the problem in any way? No ❒ Yes ❒ If yes, how?

_____

_____

_____

How confident are you that these goals can be met? Confident / Not confident / I'm not sure

Who needs to be involved in the therapeutic process in order to accomplish your goals?

_____

_____

What would the people that know you best say about the problem you are coming in for?

_____

_____

Describe your greatest accomplishments – the things you are proudest of:

_____

_____

How can the "lessons learned" during these accomplishments help you resolve this problem?

_____

_____

FAMILY INFORMATION

Spouse #1 /Significant Other: Name:_____Current Age:_____
Wedding date:_____Divorce date:_____Children from this relationship:_____
Education:_____Occupation:_____
History of mental health issues/diagnosis/treatment: YES NO What type?_____
History of abusing alcohol or other drugs: YES NO Which?_____
Legal problems (arrests, jail time, fines)? YES NO What type?_____

Spouse #2 /Significant Other: Name:_____Current Age:_____
Wedding date:_____Divorce date:_____Children from this relationship:_____
Education:_____Occupation:_____
History of mental health issues/diagnosis/treatment: YES NO What type?_____
History of abusing alcohol or other drugs: YES NO Which?_____
Legal problems (arrests, jail time, fines)? YES NO What type?_____
(arrests, jail time, fines)? YES NO What type?_____

Father: Name:_____Current Age:_____
Wedding date:_____Divorce date:_____Children from this relationship:_____
Education:_____Occupation:_____
History of mental health issues/diagnosis/treatment: YES NO What type?_____
History of abusing alcohol or other drugs: YES NO Which?_____
Legal problems (arrests, jail time, fines)? YES NO What type?_____

Mother: Name:_____Current Age:_____
Wedding date:_____Divorce date:_____Children from this relationship:_____
Education:_____Occupation:_____
History of mental health issues/diagnosis/treatment: YES NO What type?_____
History of abusing alcohol or other drugs: YES NO Which?_____
Legal problems (arrests, jail time, fines)? YES NO What type?_____

CLIENT: _____ **DOB:**_____**SOCIAL SECURITY #:** _____

Do you have brothers or sisters? No ❒ Yes ❒ If yes,

History of mental health issues/diagnosis/treatment: YES NO What type?_____

History of abusing alcohol or other drugs: YES NO Which?_____

Legal problems (arrests, jail time, fines)? YES NO What type?_____

Do you have children or step children? No ❒ Yes ❒

Names and ages?_____

_____

_____

Any history of mental health issues/diagnosis/treatment? No ❒ Yes ❒ Who and what type?

_____

_____

_____

Any history of abusing alcohol or other drugs? No ❒ Yes ❒ Who and what type?

_____

_____

_____

Any legal problems (arrests, jail time, fines)? No ❒ Yes ❒ Who and what type?

_____

_____

_____

Please describe how well you get along with family members.

_____

_____

_____

_____

CLIENT: _____ **DOB:** _____ **SOCIAL SECURITY #:** _____

Please describe where you lived during your childhood, when, with whom, and who had custody.

_____

_____

_____

SOCIAL HISTORY

Have you ever been abused?

Physically? No ❒ Yes ❒ If yes, by whom? _____

Emotionally? No ❒ Yes ❒ If yes, by whom? _____

Sexually? No ❒ Yes ❒ If yes, by whom? _____

Do you have a best friend? No ❒ Yes ❒ If yes, M or F Current age_____How long? ____

About how many close friends do you have? _____

How often do you socialize outside of working hours? _____

What kinds of social activities do you enjoy? _____

_____

Do you currently have any financial concerns? No ❒ Yes ❒ What type?

_____

_____

Have you ever had any legal problems (arrests, jail time, fines)? No ❒ Yes ❒ What type?

_____

_____

Do you currently have any concerns about your safety? No ❒ Yes ❒

If yes what are you concerned about and from whom?

_____

_____

_____

CLIENT: _____ **DOB:** _____ **SOCIAL SECURITY #:** _____

EDUCATIONAL HISTORY

List all schools attended, with city, degrees, and dates:

_____

_____

Ever repeat a grade? No ❒ Yes ❒ When? _____

General performance in school, e.g., all A's, mostly C's, etc.: _____

Any problems with school? When? _____

In Special Education? What areas? _____ When? _____

Last grade completed/degrees earned: _____

Strengths: _____

Weaknesses: _____

WORK HISTORY

Age when you got your 1st job? _____ What was it? _____

All other jobs, with dates: _____

_____

What kinds of problems did you have at these jobs? Ever been fired?

_____

_____

How many jobs have you had in the last 5 years? _____

Have you ever been fired? Yes❒ No❒ Why? _____

_____

Current employer: _____ Position: _____

Annual income: _____ Shift/work hours: _____ Hours /week: _____

How long at current job? _____ Job satisfaction: 1-10 (1=poor, 10=excellent) _____

Any job performance problems? _____

_____

_____

CLIENT: _____ **DOB:** _____ **SOCIAL SECURITY #:** _____

MENTAL HEALTH HISTORY

Please describe mental health issues you have experienced in your life

	EPISODE 1	EPISODE 2	EPISODE 3
Date			
Problem/Diagnosis			
Provider/Phone			
Frequency/Duration			
Medication			
Outcome			

Additional Information _____

_____

_____

Family Mental Health History: No ❒ Yes ❒ If yes, please explain your relationship, the diagnosis, and treatment received. _____

_____

_____

_____

	No	**Yes**	**Comments**
Past suicide attempts by you	____	____	_____
Family history of suicide	____	____	_____
Past homicide attempts/violence	____	____	_____
Family history of homicide/violence	____	____	_____

Any other information I should know about your mental health history?

_____

_____

_____

_____

CLIENT: _____ **DOB:**_____**SOCIAL SECURITY #:** _____

Do you **currently** have any ideas, intentions, or plans of hurting yourself or others?
No ❒ Yes ❒ If yes, please describe below:

Current:	**Ideas**	**Intention**	**Plan**	**Comments**
Suicide	_____	_____	_____	_____
Homicide/violence	_____	_____	_____	_____

Describe any current ideas, intentions, or plans:_____

_____

_____

CURRENT AND PAST SUBSTANCE USE (Including tobacco and over-the-counter medications)

Substance Used	First Use (Age)	Date of Last Use	How often is it used?	Amount	How is it taken?
Alcohol					
Cocaine/ Crack					
Marijuana					
Hallucinogens					
Crystal Meth					
Heroin					
Tobacco					

History of Abuse-Related Symptoms (Check all that Apply)

____Blackout ____Withdrawal ____Progression of Use
____Convulsions/Seizures ____Tremors ____Increased Tolerance
____Sleep Disturbance ____ Appetite Disturbance ____Loss of Control
____Gastrointestinal Problems ____Other (explain)_____

CLIENT: _____ **DOB:**_____**SOCIAL SECURITY #:** _____

Attempts to Stop/Control Use/Abuse:_____

_____

_____

_____

_____

History of Prior Substance Abuse Treatment ____None ____Yes (specify below)

Provider/Facility	Dates	Inpatient	Outpatient	Self-Help	Completed?

Consequences of Substance Use ____None ____Yes (Check all that apply)

____Marriage/Intimate Relationships ____Emotional ____Accidents
____Friends/Social Relationships ____Family/Children ____Work/School
____Legal ____Financial ____Health
____Other (Specify)_____

_____

_____

History of Substance Use in Family or Significant Relationships ____None ____Yes (explain)

_____

_____

_____

_____

_____

_____

_____

CLIENT: _____ DOB:_____SOCIAL SECURITY #: _____

MEDICAL HISTORY

When was the date of your last physical exam? _____By Dr:_____

Please describe medical problems in the past 5 years:

Date	Diagnosis / medication / treatment	Doctor

CURRENT MEDICATIONS

Name of Medication	Current Dosage & Frequency	Start Date

IS THERE ANYTHING ELSE I SHOULD KNOW THAT WOULD HELP ME HELP YOU?