CLIENT INFORMATION & HISTORY

Turner Professional Counseling, PLLC
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All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Client Name _____
Address _____ City_____ Zip Code _____
Best phone number and time to reach you: _____May I leave a message? Y / N
Age _____ Birthdate ____/____/_____ Education Completed: _____
Name(s) & age(s) of child(ren)_____
Who lives in the household?_____
Emergency contact: _____Relationship _____ Phone # _____
Who referred you to me? _____ May I thank this person for the referral? Y / N
Employer/Occupation _____
Employment Status: __ Full-time __ Part-time __ Choose to stay at home __ Unemployed
Are you happy at your current position? _____
Please list any work-related stressors: _____
What concerns lead you to therapy at this time?_____
_____
_____
What goals do you have for therapy?_____
_____
_____
Are you currently receiving psychiatric care or psychotherapy elsewhere? Y / N
If Yes, with whom? _____
Please describe any previous therapy experience: _____
_____
Are you currently taking prescribed psychiatric medication (antidepressants, etc)? Y / N
If Yes, please list: _____
Please list medications taken in the past: _____
Have you ever been hospitalized for psychiatric reasons? Y /N
If yes, describe: _____
Have you thought about or attempted suicide? Y / N
If yes, please describe: _____
Have you ever intentionally hurt yourself? Y / N If so when and what happened?_____
_____

HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns: _____
_____
Current medications: _____
Primary care physician: _____ Phone # _____
Are you having any problems with sleep? Y / N If so, describe: _____
What are your exercise habits? _____
Are you having any difficulty with appetite, weight or eating habits? Y / N
If yes, describe: _____

Do you smoke or use tobacco? Y / N Please describe: _____
Do you drink alcohol? Y / N Please describe: _____
Do you use other/recreational drugs? __ Daily __Often __ Rarely __ Never __ Not any more
If at all, please describe: _____
Have you ever experienced a concussion or other head injury? If yes, list date(s) and information known:_____
Current relationship status: Single Dating Separated Living together Married Divorced Widowed
If applicable, please describe the quality of your current relationship: _____
_____
Please describe your relationship history: _____
What of the following have you experienced in yourself in the **past year**? (Circle all that apply)

Chronic Pain or Illness	Concentration or Memory Difficulty
Major Life Change	Compulsive or Impulsive Behaviors
Financial Problems	Restlessness
Grief/Loss	Sexual Dysfunction
Legal Problems	Social Discomfort/Shyness
Spiritual Confusion	Identity Confusion
Family or Parenting Conflicts	Loneliness
Other (specify): _____	Trauma or disturbing life experience

FAMILY MENTAL HEALTH HISTORY:

Check if yes	Who?	Received treatment?
__ Depression	_____	Y / N
__ Bipolar Disorder	_____	Y / N
__ Anxiety Disorders	_____	Y / N
__ Panic Attacks	_____	Y / N
__ Schizophrenia	_____	Y / N
__ Addiction	_____	Y / N
__ Eating Disorders	_____	Y / N
__ Learning Disabilities	_____	Y / N
__ ADHD	_____	Y / N
__ Trauma/Abuse History	_____	Y / N
__ Suicide Attempts	_____	Y / N

Briefly describe your relationship with your:
Mother: _____
Father: _____
Sibling(s): _____
Extended family: _____
Child(ren): _____
Do you consider yourself to be religious? Y / N If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? Y / N
Do you feel that your faith should be a significant part of your therapy? Y / N
Please describe: _____
What do you consider to be your strengths?_____
_____
What do you like most about yourself?_____
_____
How do you typically cope with problems in your life? _____
_____

Adverse Childhood Experiences Scale

These questions are based on the Adverse Childhood Experiences Study, originally by Kaiser Permanente in 1997.

See www.acestudy.org for more information.

Please circle "yes" or "no" for each question below.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**... Swear at you, insult you, put you down, or humiliate you? **Or -** Act in a way that made you afraid that you might be physically hurt?

Yes / No

2. Did a parent or other adult in the household **often or very often**...

Push, grab, slap, or throw something at you? **Or - Ever** hit you so hard that you had marks or were injured?

Yes / No

3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way? **Or** - Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes / No

4. Did you **often or very often** feel that ...No one in your family loved you or thought you were important or special?

Or - Your family didn't look out for each other, feel close to each other, or support each other?

Yes / No

5. Did you **often or very often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes / No

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?

Yes / No

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her?

Or - **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **Or** - **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes / No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes / No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes / No

10. Did a household member go to prison?

Yes / No

Is there anything else you want me to know? _____

_____

Client Signature _____ Date _____