**Patient Demographic Information**

**A. Identification**

Your name:

Date of birth:

Age:

Nicknames or aliases:

Full home street address:

Home phone number:

Cell phone number:

\*E- mail address:

\*by including your email address, you are granting permission that I communicate with you by email.

Because email is not a completely secure form of communication, I am unable to ensure the

confidentiality of information transmitted by email.

**B. Reason for Referral:**

Referral Source:

1. What brings you here today? How would you describe your problem?

2. What troubles you most about your problem?

3. Why do you think this is happening to you?

**C. Personal Identity**

Ethnicity/national origin:

Race:

Gender:

Current spiritual or religious beliefs:

How important are spiritual concerns in your life?

Would you like your spiritual/religious beliefs to be utilized in your counseling? How?

**Background Information: Please provide the following information:**

1. When and where were you born, what was your birth situation, describe your developmental

milestones:

2. Do you have any disabilities (past/present)?

3. Family of origin and present family names and ages; brief description of your relationship with

each one past/present:

4. Describe five of your most significant others (what your relationship felt like to you) and the

positive or negative impact growing up with them had on you (the positive/negative thoughts,

feelings, and memories) [people you knew between birth and 16 years old].

|  |  |
| --- | --- |
| **Name/Relationship**  **(Ages birth-16)** | **Impact on You** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

1. Describe five of your present most significant others (what your relationship feels like to you)

and the positive or negative impact they have on you (the positive/negative thoughts and feelings)

[people you are presently in a relationship with].

|  |  |
| --- | --- |
| **Name/Relationship**  **(Present)** | **Impact on You** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

2. Did you experience moves, deaths, losses, discrimination, or bullying (receiving or giving)

growing up?

3. Coping Behaviors Past/Present: Did you use drugs/alcohol/substances/other addictions and

coping behaviors?

4. Significant other’s coping behaviors: Did your parents, siblings, extended family, or other

significant others use drugs/alcohol/substances/other addictions and coping behaviors?

5. History of friendships:

6. Financial problems:

7. Dating history, sexual history, courtship, marriage, ages of children, past and current relationship with each present family member, current living situation, current sexual concerns:

8. Description of your parents, your relationship with each of your parents, your parent’s

relationship with each other, where they met, their parent’s reaction to their relationship,

information about their courtship, wedding, and marriage. What did your parents do for a living?

9. Grandparents birth location (both sets), your relationship with each of your grandparents, their

relationship with each other, their relationship with your parents, their relationship with your

parent’s other siblings in your parent’s family, and their spiritual/religious beliefs. What did your

grandparents do for a living?

10. Describe any significant relationships you had with extended family members.

11. Extended family problems (past/present):

12. Schools you attended, grades, relationships with teachers, relationships with peers, and degrees you earned:

13. Employment History: List general dates, name of employer, job type/title, and reason for leaving.

Your current employer:

Work phone:

Are there any other comments about your present work or work history you want to share?

14. Do you currently receive SSI or Disability Benefits?

❑Yes ❑No Year benefits began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the disability your benefits are based upon:

15. Trauma/Disaster/Frightening Events History:

16. Abuse history (abandonment; emotional, physical, sexual, spiritual, and/or psychological abuse or deprivation; or the presence of these in your family, neighborhood, or school environment):

17. Present or past self-harm (including cutting or burning self, eating disorders, unkind/cruel

relationship with yourself, promiscuity, reckless behaviors, suicide attempts, perfectionism, selfsacrifice/subjugation of self, other addictions/obsessions):

18. Health problems:

You (past/present):

Significant family members (past/present):

19. Thoughts of suicide or harming someone else (past/present):

20. Military History (you or significant others):

21. Legal History (you or significant others):

22. Date of your last complete physical (including blood work measuring thyroid functioning and

other hematological indices):

Name of MD, address, and phone number:

23. Treatment History: psychiatric, counseling, medical. Have you ever been in residential treatment?

24. If you were in previous mental health counseling was it helpful? Why or why not?

25. Name and phone numbers of a person I have permission to contact in case of emergency:

26. Anything else that you think might be helpful to share with me?

**Presenting Bio-Psycho-Social-Spiritual Problems:**

A. Painful Thoughts (list specific thoughts that you want to change and rate [1(extremely mild) -10

(severe)] how disturbing each of these specific thoughts are:

1.

2.

3.

4.

5.

B. Painful Feelings: (List specific feelings that you want to change and rate [1(extremely mild) -10

(severe)] how disturbing each of these specific feelings are:

1.

2.

3.

4.

5.

C. Painful Social Symptoms/Concerns: (List specific social symptoms/concerns that you want to change

and rate [1(extremely mild) -10 (severe)] how disturbing each of these specific concerns are:

1.

2.

3.

4.

5.

D. Behaviors of Concern: (List specific behaviors that you want to change and rate [1(extremely mild) -

10 (severe)] how disturbing each of these specific concerns are:

1.

2.

3.

4.

5.

E. Spiritual Issues (list specific issues that you want to address and rate [1(extremely mild) -10 (severe)]

how disturbing each of these specific issues are:

1.

2.

3.

4.

5.

F. Physical Concerns (i.e. medical, sexual, eating, exercise, sleeping, substance/alcohol use, etc.) [List

specific concerns that you want to change and rate [1(extremely mild) -10 (severe)] how disturbing each

of these specific concerns are:

1.

2.

3.

4.

5.

Goals: Based on the above, what would you most like to see change as a result of counseling? Please

describe and number in the order of importance to you:

These specific painful thoughts:

These specific painful feelings:

These painful social concerns:

The specific behaviors:

These specific spiritual concerns:

These specific physical concerns:

How would you know we met your goals in counseling? What would be different (be specific)? How

motivated are you to reach these goals? Are you ready to work hard to reach your goals?

What might get in the way of successfully reaching your goals in counseling?

What might help you (outside of the counseling sessions) reach your goals in counseling?

Additional Comments:

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