

# HEALING HEART

341 N. Caswell Rd.

Charlotte, NC 28204

704-565-9212

johanna@healingheartcharlotte.com

healingheartcharlotte.com

## Client History and Information Questionnaire

### General Information:

Client Name:

Date:

Last 4 digits of Social Security Number:

Date of Birth:

Gender:  Male  Female  I do not identify as male or female

Ethnicity:

Home Address:

Home Phone Number:

May we leave a message?  Yes  No

Work Phone Number:

May we leave a message?  Yes  No

Mobile Phone Number:

May we leave a message?  Yes  No

Email Address:

May we email you?  Yes  No

\*Please note email correspondence is not considered to be a confidential medium of communication.

### Insurance Information if applicable:

If you will be using insurance to cover all or a portion of the cost for your sessions please complete the following and allow us to make a photocopy of your insurance card.

Primary Insurance Company:

### Emergency Contact Information:

In case of an emergency, whom should we contact?

Name:

Relationship:

Address:

Phone Number:

**Referral Source:**

Who referred you to Healing Heart, or how did you learn about the practice?

To the best of your knowledge, why were you referred?

**History Information:**

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Please check all words/phrases that describe what you are experiencing and explain below if possible.

- |  |   |
|--|---|
| <input type="checkbox"/> Depression/Sad/Down feelings                                | <input type="checkbox"/> Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.) |
| <input type="checkbox"/> High/Low energy level (if checked circle high, low or both) | <input type="checkbox"/> Change in weight or appetite   |
| <input type="checkbox"/> Angry/Irritable   | <input type="checkbox"/> Change in sleeping pattern   |
| <input type="checkbox"/> Loss of interest in activities                              | <input type="checkbox"/> Suicidal thoughts or plans/Thoughts of hurting yourself                |
| <input type="checkbox"/> Difficulty enjoying things                                  | <input type="checkbox"/> Self-harm/Cutting/Burning yourself                                     |
| <input type="checkbox"/> Crying spells   | <input type="checkbox"/> Homicidal thoughts or plans/Thoughts of hurting others                 |
| <input type="checkbox"/> Decreased motivation  | <input type="checkbox"/> Poor concentration/Difficulty focusing                                 |
| <input type="checkbox"/> Withdrawing from people/Isolation                           | <input type="checkbox"/> Feelings of hopelessness/Worthlessness                                 |
| <input type="checkbox"/> Mood swings   | <input type="checkbox"/> Feelings of shame or guilt   |
| <input type="checkbox"/> Black-and-white thinking/All-or-nothing thinking            | <input type="checkbox"/> Feelings of inadequacy/Low self-esteem                                 |
| <input type="checkbox"/> Negative thinking   | <input type="checkbox"/> Anxious/Nervous/Tense feelings   |
| <input type="checkbox"/> Substance abuse/dependence                                  | <input type="checkbox"/> Panic attacks  |

- Racing or scrambled thoughts
- Bad or unwanted thoughts
- Flashbacks/Nightmares
- Muscle tensions, aches, etc.
- Hearing voices/Seeing things not there
- Thoughts of running away
- Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
- Feelings of frustration
- Feelings of being cheated
- Perfectionism
- Rituals of counting things, washing hands, checking locks, stove, etc./Overly concerned about germs
- Distorted body image (believe you are heavier or less attractive than others say you are)
- Concerns about dieting
- Feelings of loss of control over eating
- Binge eating/Purging
- Rules about eating/Compensating for eating
- Excessive exercise
- Indecisiveness about career
- Job problems
- Other:

Please explain all symptoms that you checked in the space below.

**Previous Treatment:**

Have you received or participated in previous counseling and/or therapy?  Yes  No

If yes, please fill in the chart below.

Name of Clinician/Practice	Dates of Treatment	Reason for Treatment	Outcome of Treatment

Have you had hospital stays for psychological concerns?  Yes  No

If yes, please fill in the chart below.



Are you currently trying to conceive?  Yes  No

Are you experiencing fertility challenges?  Yes  No

If you are a female, have you ever been pregnant before?  Yes  No

Please explain any current or past fertility challenges.

How would you rate your current physical health?

Excellent  Very Good  Good  Fair  Poor  Very Poor

### **Family History**

Birth Location:

Whom were you raised by?

Were you adopted?

Did you grow up in a home with domestic violence during any time in your life?

Is there any history of neglect, and/or physical, verbal, emotional, or sexual abuse in your life? If yes, please elaborate.

Is there any family history of substance abuse, mental illness, suicide, or violence? If yes, please elaborate.

Please list any additional family information that might have a bearing on your current complaint.

## **Social History**

Please describe your relationship with peers and/or friends?

How would you describe your social support network?

Please describe your hobbies/interests.

Please describe any important cultural factors.

## **Educational History**

When attending school were you (please check all that apply):

- In regular classes
- Homeschooled
- In special education classes
- In advanced classes
- Ever suspended
- Placed in alternative school

What is the highest educational level you have completed?

Please give any additional important educational information. (e.g Did you like school? Did you have a learning disability? Were you bullied in school?)

## **Occupational History**

What is your current employment status?

- Employed Full-Time
- Employed Part-time
- Stay-at-home Mother/Father
- Unemployed
- Self-employed
- Student
- Other

Are you satisfied with your employment?  Yes  No  
If not, why not?

### **Relationship History**

Which best describes your relationship status?

- Married, Date: \_\_\_\_\_
- Never Married
- In a Committed Relationship, Date: \_\_\_\_\_
- Widowed, Date: \_\_\_\_\_
- Separated, Date: \_\_\_\_\_
- Divorced, Date: \_\_\_\_\_

If you are married or partnered, please briefly describe the nature of your relationship:

If you are married or partnered, which best describes your satisfaction? Feel free to elaborate.

- Poor  Fair  Average  Good  Great

Have you ever been in a physically, emotionally, or sexually abusive relationship?  Yes  No

If yes, please elaborate.

Is your current partner physically, emotionally, or sexually abusive?  Yes  No

If yes, please elaborate.

Do you have children?  Yes  No

If yes, please complete the following:

<b>Child's Full Name</b>	<b>Child's DOB</b>	<b>Child's Gender</b>	<b>Nature of Relationship with Child</b>	<b>Child Custody Issue with Child</b>

Does your family currently have Child Protective Services (CPS) Involvement?  Yes  No

If yes, please complete the following:

Case Worker's Name:

Case Worker's Phone Number:

Reason for CPS/DSS involvement:

Has your family ever in the past had Child Protective Services Involvement?  Yes  No

If yes, please elaborate.

**Substance Abuse History**

Please note substance abuse includes, but is not limited to alcohol, tobacco, marijuana, caffeine, prescription drug abuse, over-the-counter drug abuse or illegal drugs.

Are you currently struggling with substance abuse?  Yes  No

Have you previously struggled with substance abuse?  Yes  No

Do you currently use any substances (including alcohol)?  Yes  No

If yes, please list the substances you are currently using and explain the frequency of use.



Do you have any concerns about your current use of substances?  Yes  No

If yes, please elaborate.

Please complete the following chart if you have ever received treatment for a substance abuse issue.

<b>Name of Treatment Program</b>	<b>Type of Treatment</b> (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)	<b>Date of Treatment</b> (Month, Year)	<b>Outcome</b> (Any Clean time?)

**Legal History**

Do you currently have any pending criminal charges?  Yes  No

Are you on probation?  Yes  No

Name of Probation Officer and County:

Have you ever been arrested/convicted of a crime?  Yes  No If yes, please complete chart.

<b>List any Arrests/Convictions</b>	<b>Date of Arrests/Convictions</b>	<b>Outcome</b> (Served time, Community Service, Drug/Alcohol Treatment, etc.)	<b>Additional Information</b>

**Additional Information:**

Do you consider yourself to be a spiritual or religious person? If yes, please elaborate.

Are you satisfied with where you are in your life? [ ] Yes [ ] No

If not, where would you like to be?

Please summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

If you are pursuing couples counseling please share your goals for your partner.

What are your strengths?

What are your weaknesses?

Are you comfortable with well-behaved dogs? [ ] Yes [ ] No

Please write any additional information that you believe is important for your therapist to know in order to provide you with the best care possible.

By signing below, you are acknowledging that the information you provided is true to the best of your knowledge.

Signature of Client: \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Client: \_\_\_\_\_

