HEALING HEART

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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 your 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.

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

Hospital	Dates of Stay	Voluntary or Involuntary Stay	Reason for Stay	Outcome of Stay

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

If yes, please elaborate.

Have you in the past experienced thoughts of harming either yourself or someone else? [ ] Yes [ ] No

If yes, please elaborate.

Medical History

List any current medications or important past medications (please include all psychiatric medications):

Medication Name	Dose	Time Period on Medication	Reason for Going on Medication	Reason for Stopping Medication	Impact of Medication or Important Side Effects

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:

Child's Full Name	Child's DOB	Child's Gender	Nature of Relationship with Child	Child Custody Issue with Child

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.

Name of Treatment Program	**Type of Treatment** (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)	**Date of Treatment** (Month, Year)	**Outcome** (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.

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

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: _____________________________________