Be. Counseling Partners

Personal History Form

Please bring this completed to your first appointment.

Client Name: _____(DOB)_____ Today's Date: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: (cell)_____ (work)_____(home)_____

Can we leave a message? Cell (yes/no) work (yes/no) home (yes/no)

Email: _____

Special Instructions: _____

I understand that the caller ID may disclose the therapist's name/company name to others and that email may not be confidential. Initial: _____

Emergency Contact: _____

Relationship: _____ phone: _____

What are your reasons for seeking help at this time? _____

_____

Client History:

Name of Junior High/Middle school/High School (Adolescent Client) _____

Highest level of education achieved _____

Occupation: _____ Employer: _____ Disabled: _____

Do you receive financial assistance? _____

Ethnic/Cultural/tribal Background: _____

Gender/Sexual orientation: _____ Primary Language: _____

Marital Status:

____single, ____married, ____partnered, ____separated, ____divorced, ____widowed

Religious/Spiritual affiliation: _____

Legal Concerns: _____

Hobbies/Interests: _____

Strengths: _____

Family History:

Currently living with: _____

Do you feel safe in your home? __yes/no Currently living in: house__, apartment__, other____

Spouse/Partner (name, age, occupation): _____

Children (name, age if any): _____

_____Pets (if any): _____

Do you have adequate support (include friends, family)? _____

_____

Any significant concerns regarding family of origin: _____

_____

Health History:

Allergies (food, drugs, other): _____

Current medications: _____

_____

Have you ever received therapy/counseling before? ___yes, ____no

If yes, please describe when and why: _____

_____

Have you been hospitalized in the past? _____

Have you been abused (physical/emotional/sexual)?_____

Who is your physician/primary health care provider? _____

When was your last physical? _____

Do you have ongoing medical concerns? _____

Have you ever had surgery? _____

Do you drink alcohol? _____ use tobacco? _____ caffeine? _____ drugs? _____

Is alcohol/other chemical use problematic for you? _____

Have you completed chemical dependency treatment? _____

How did you hear about **Be. Counseling Partners**? _____