Peoples Counseling & Consulting

"Improved relationships with oneself & others"

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Jay Peoples MS, MSW, LCSW

History/Adult

Name **Date**

Date of Birth **Age**

Gender

Address

City **State**

Zip code

Cell Phone

Home Phone

Work Phone

E-mail

Primary Reason for seeking services

❑ Anger Management	❑ Coping
❑ Eating Disorder	❑ Mental Confusion
❑ Sleeping Problems	❑ Alcohol/drugs
❑ Anxiety	❑ Depression
❑ Fear/Phobias	❑ Sexual concerns
❑ Addictive behaviors	❑ Other mental health concerns

FAMILY INFORMATION

Mother	**Age**	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
Father	**Age**	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
Spouse	**Age**	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
Children	**Age**	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
	Age	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
	Age	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
	Age	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
	Age	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No
	Age	**Living:** ❑ Yes ❑ No	**Living with you:** ❑ Yes ❑ No

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Significant Others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship).

Relationship/ Name

	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No
	Age	Living: ❑ Yes ❑ No	Living with you: ❑ Yes ❑ No

Marital Status (more than one answer may apply)

❑ Single	Length of time
❑ Legally married	Length of time
❑ Unmarried, living together	Length of time
❑ Separated	Length of time
❑ Divorce in process	Length of time
❑ Divorced	Length of time
❑ Widowed	Length of time
❑ Annulment	Length of time

Total number of marriages:

Assessment of current relationship (if applicable) ❑ Good ❑ Fair ❑ Poor

Parental Information

❑ Parents legally married ❑ Parents have ever been separated

❑ Parents ever divorced

❑ Mother remarried Number of times:

❑ Father remarried Number of times:

❑ Special circumstances (raised by person other than parents, information about spouse/ children not living with you, etc.):

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? ❑ Yes ❑ No

If yes, please describe:

Has there been any history of child abuse? ❑ Yes ❑ No

If yes, which type(s) ❑ Sexual ❑ Physical ❑ Verbal ❑ Emotional

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DEVELOPMENT - CONTINUED

If yes, the abuse was as a: ❑ Victim ❑ Perpetrator ❑ Both

Other childhood issues: ❑ Neglect ❑ Inadequate nutrition

❑ **Other (please specify):**

Comments regarding childhood development:

SOCIAL RELATIONSHIPS

Please check how you generally get along with other people:

❑ Affectionate ❑ Aggressive ❑ Avoidant ❑ Fight/ argue often ❑ Follower ❑ Friendly ❑ Leader ❑ Outgoing

❑ Affectionate ❑ Shy/ withdrawn ❑ Submissive

❑ **Other (specify):**

Sexual orientation: **Comments:**

Sexual dysfunction? ❑ Yes ❑ No

If Yes, describe:

Any current or history of being a sexual perpetrator? ❑ Yes ❑ No

If Yes, describe:

CULTURAL/ ETHNIC

To which cultural or ethnic group, if any, do you belong?

Are you experiencing any problems due to cultural or ethnic issues? ❑ Yes ❑ No

If Yes, describe:

Other cultural/ ethnic information:

SPIRITUAL/ RELIGIOUS

How important to you are spiritual matters? ❑ Not ❑ Little ❑ Moderate ❑ Much

Are you affiliated with a spiritual or religious group? ❑ Yes ❑ No

If Yes, describe:

Were you raised within a spiritual or religious group? ❑ Yes ❑ No

If Yes, describe:

Would you like your spiritual or religious beliefs incorporated into the counseling? ❑ Yes ❑ No

If Yes, describe:

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LEGAL

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ❑ Yes ❑ No

If Yes, please describe and indicate the court and hearing/ trial dates and charges:

Are you presently on probation or parole? ❑ Yes ❑ No

If Yes, please describe:

Past History

Traffic violations ❑ Yes ❑ No DWI, DUI, Etc. ❑ Yes ❑ No Criminal involvement ❑ Yes ❑ No

If Yes, to any of the above, please fill in the following information:

Charges	Date	Where (City)	Result

EDUCATION

(Fill in all that apply) Years of education:

Currently enrolled in School? ❑ Yes ❑ No

High School grad/ GED Year Graduated

❑ Vocational Number of years Graduated ❑ Yes ❑ No Major:

❑ College Number of years Graduated ❑ Yes ❑ No Major:

❑ Graduate Number of years Graduated ❑ Yes ❑ No Major:

❑ Other training:

Special circumstances (e.g., learning disabilities, gifted):

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently ❑ Full time ❑ Part time ❑ Temporary ❑ Laid-off

❑ Disabled ❑ Retired ❑ Student ❑ Social Security

❑ Other (describe):

MILITARY

Military experience? ❑ Yes ❑ No Combat experience? ❑ Yes ❑ No

Where? ❑ Disabled ❑ Retired ❑ Student ❑ Social Security

Branch Discharge date

Date drafted Type of discharge

Date enlisted Rank at discharge

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LEISURE/ RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/ health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

MEDICAL/ PHYSICAL HEALTH

(Check all that apply)

❑ AIDS	❑ Dizziness	❑ Nose bleeds	❑ Alcoholism	❑ Drug abuse	❑ Pneumonia
❑ Abdominal pain	❑ Epilepsy	❑ Rheumatic Fever	❑ Abortion	❑ Ear infections	❑ STD's
❑ Allergies	❑ Eating problems	❑ Seizures	❑ Anemia	❑ Fainting	❑ Sleeping disorders
❑ Appendicitis	❑ Fatigue	❑ Sore throat	❑ Arthritis	❑ Frequent urination	❑ Scarlet Fever
❑ Asthma	❑ Headaches	❑ Sinusitis	❑ Bronchitis	❑ Hearing problems	❑ Smallpox
❑ Bed wetting	❑ Hepatitis	❑ Stroke	❑ Cancer	❑ Heart Problems	❑ Sexual problems
❑ Chest pain	❑ Kidney problems	❑ Tonsillitis	❑ Chronic pain	❑ High blood pressure	❑ Tuberculosis
❑ Colds/ Coughs	❑ Mononucleosis	❑ Toothache	❑ Constipation	❑ Measles	❑ Thyroid problems
❑ Chicken Pox	❑ Menstrual pain	❑ Vision problems	❑ Dental problems	❑ Mumps	❑ Vomiting
❑ Diabetes	❑ Neurological disorders	❑ Whooping cough	❑ Diarrhea Nausea	❑ Miscarriages	

List any current health concerns:

List any recent health or physical changes:

NUTRITION

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Lunch	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Dinner	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Snack	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High

Comments:

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter medications	Dose	Dates	Purpose	Side effects

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NUTRITION - CONTINUED

Are you allergic to any medications or drugs? ❑ Yes ❑ No

If Yes, please describe:

Last physical exam	**Date**	**Reason**	**Result**
Last doctor's visit	**Date**	**Reason**	**Result**
Last dental exam	**Date**	**Reason**	**Result**
Most recent surgery	**Date**	**Reason**	**Result**
Other surgery	**Date**	**Reason**	**Result**
Upcoming surgery	**Date**	**Reason**	**Result**

Family history of medical problems

Please check if there have been any recent changes in the following:

❑ Sleep patterns ❑ Eating patterns ❑ Behavior ❑ Energy level ❑ Physical activity level

❑ General disposition ❑ Weight ❑ Nervousness/ tension

Describe changes in areas in which you checked above:

CHEMICAL USE

Substance	Method of use & amount	Frequency of use	Age of first use	Age of last use	Last 48 hrs	Last 30 days
Alcohol					❑ Yes ❑ No	❑ Yes ❑ No
Barbiturates					❑ Yes ❑ No	❑ Yes ❑ No
Valium/ Librium					❑ Yes ❑ No	❑ Yes ❑ No
Cocaine/ Crack					❑ Yes ❑ No	❑ Yes ❑ No
Heroin/ Opiates					❑ Yes ❑ No	❑ Yes ❑ No
Marijuana					❑ Yes ❑ No	❑ Yes ❑ No
PCP/ LSD/ Mescaline					❑ Yes ❑ No	❑ Yes ❑ No
Inhalants					❑ Yes ❑ No	❑ Yes ❑ No
Caffeine					❑ Yes ❑ No	❑ Yes ❑ No
Nicotine					❑ Yes ❑ No	❑ Yes ❑ No
Over-the-counter					❑ Yes ❑ No	❑ Yes ❑ No
Prescription dugs					❑ Yes ❑ No	❑ Yes ❑ No
Other drugs					❑ Yes ❑ No	❑ Yes ❑ No

Substance of preference: 1) 2)

3) 4)

Substance Abuse Questions

Describe when and where you typically use substances:

Describe any changes in your use patterns:

Describe how your use has affected your family or friends (include their perceptions of your use):

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Substance Abuse Questions - Continued

Reason(s) for use: ❑ Addicted ❑ Build confidence ❑ Escape ❑ Self-medication ❑ Socialization ❑ Taste

Other (specify):

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? ❑ Yes ❑ No

If Yes, describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ❑ Yes ❑ No

If Yes, describe:

Have you had adverse reactions or overdose to drugs or alcohol? (describe): ❑ Yes ❑ No

If Yes, describe:

Does your body temperature change when you drink? ❑ Yes ❑ No

If Yes, describe:

Have drugs or alcohol created a problem for your job? ❑ Yes ❑ No

If Yes, describe:

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	(Please check one)	When	Where	Your reaction to overall experience
Counseling/Psychiatric Treatment	❑ Yes ❑ No			
Suicidal thoughts/attempts	❑ Yes ❑ No			
Drug/alcohol treatment	❑ Yes ❑ No			
Hospitalizations	❑ Yes ❑ No			
Involvement with self-help				
(e.g., AA, Al-non, NA)	❑ Yes ❑ No			

Information about family/significant others (past and present):

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	(Please check one)		When	Where	Your reaction to overall experience
Counseling/Psychiatric Treatment	❑ Yes	❑ No			
Suicidal thoughts/attempts	❑ Yes	❑ No			
Drug/alcohol treatment	❑ Yes	❑ No			
Hospitalizations	❑ Yes	❑ No			
Involvement with self-help (e.g., AA, Al-non, NA)	❑ Yes	❑ No			

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

❑ Aggression	❑ Distractibility	❑ Hopelessness	❑ Sexual addiction
❑ Alcohol dependence	❑ Dizziness	❑ Impulsivity	❑ Sexual difficulties
❑ Anger	❑ Drug dependence	❑ Irritability	❑ Sick often
❑ Antisocial behavior	❑ Eating disorder	❑ Judgment errors	❑ Sleeping problems
❑ Anxiety	❑ Elevated mood	❑ Loneliness	❑ Suicidal thoughts
❑ Avoiding people	❑ Fatigue	❑ Memory impairment	❑ Thoughts disorganized
❑ Chest pain	❑ Gambling	❑ Mood shifts	❑ Trembling
❑ Cyber addiction	❑ Hallucinations	❑ Panic attacks	❑ Withdrawing
❑ Depression	❑ Heart palpitations	❑ Phobias/fears	❑ Worrying
❑ Disorientation	❑ High blood pressure	❑ Recurring thoughts	

Other (specify):

Briefly discuss how the above symptoms impair your ability to function effectively:

Any additional information that would assist us in understanding your concerns or problems:

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