BACKGROUND AND PERSONAL HISTORY

Jennifer Brosenitsch, LPC

Client Name:_____

Today's Date: _____

Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Parent Phone # _____
(if under 18)

Address: _____

Home #_____ Cell #_____ Work #_____

Email: _____

Please indicate forms of communication from the therapist you **ARE COMFORTABLE** with:
□ Voicemails □ Confidential Emails □ Text messages (for scheduling purposes) □ Mail

Emergency contact_____ Phone #_____

Medical Insurance Company: _____Name of the person the plan is under _____
Group # _____ Policy # _____

Current Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed □ Remarried

Are you currently in a romantic relationship? □ Yes □ No If yes, how long? _____
On a scale of 1-10, how would you rate your relationship? ___

Do you have children? □ Yes □ No How many: _____ Ages:_____
Were you ever in Foster care or Adopted: □ Yes □ No
Who raised you? _____
Who do you live with? Please list ALL PEOPLE who live in your household and their relationship with you.
(Names are not necessary) _____
_____

Would you like to discuss your faith during this therapy journey? □ Yes □ No
If yes, please share your current religious affiliation and how you would like to integrate it into counseling
_____

List any significant life changes or stressful events have you experienced recently:_____
_____

Do you have any ethnicity or cultural considerations that may influence counseling:_____
_____

Educational History:
Highest level of education completed: _____
Are you currently attending school? □ Yes □ No Where: _____ Major: _____
Have you ever been diagnosed with learning disabilities?: □ Yes □ No If yes, Diagnosis:_____
What grades did you obtain in school overall? □ Above Average □ Average □ Below Average

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Client Name:_____

Current employment if any:_____
Have you ever been in the Armed Forces? □ Yes □ No
If yes, what branch:_____ Dates of service: _____

Health History:
Primary Care Doctor: _____ Phone Number: _____
Hospitalizations for medical problems:_____
_____
_____

Allergies:_____

Current medications: _____

Please check if you have experienced any of the following:

□ Visual problems	□ Hearing problems	□ Amputation	□ Diabetes	□ Seizures
□ Back/Neck Pain	□ High blood pressure	□ Migraines	□ Stomach problems	□ Head Injury
□ Arthritis	□ Asthma	□ Heart problems	□ Miscarriage	

Please specify current medical problems:_____
_____
_____

Do you smoke cigarettes or use tobacco? □ Yes □ No How frequent:_____ How much:_____

Have you ever abused drugs or alcohol (including prescription medications)? □ Yes □ No
If yes: At what age did you start abusing: _____
List all drugs/alcohol abused: _____
When was drug/alcohol last used: _____
Were you ever in outpatient or inpatient rehabilitation for drugs/alcohol? □ Yes □ No
Do you currently attend Narcotics /Alcoholics Anonymous or other support group? □ Yes □ No
How many relapses have you experienced: _____
Have you been arrested for DUI?: □ Yes □ No How many: ___ When: _____

Legal History:
Have you ever been suspended from school: □ Yes □ No
If so, how many times: ____ For what reasons:_____
Have you ever been placed within a juvenile home: □ Yes □ No
Have you ever been arrested: □ Yes □ No
If so, how many times: ____ For what reasons:_____
Have you been on probation or parole: □ Yes □ No

Problem checklist:	Current	Past		Current	Past
Difficulty sleeping	□	□	Difficulty concentrating	□	□
Memory problems	□	□	Change in appetite	□	□
No friends	□	□	Obsessive thoughts	□	□
Mood swings	□	□	Attention Deficit Disorder	□	□
Hallucinations	□	□	Post-Traumatic Stress	□	□
Intense anger	□	□			
Marital problems	□	□			
Eating disorder	□	□			

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	Current	Past	
Suicidal tendencies	□	□	If yes: How many attempts:____ Year of last attempt:_____ How did you attempt suicide:_____
Mental abuse	□	□	If yes: By whom:_____When:_____
Sexual abuse	□	□	If yes: By whom:_____When:_____
Physical abuse	□	□	If yes: By whom:_____When:_____
Psychiatric Hospitalizations	□	□	If yes: Where:_____ When:_____
Depression	□	□	If yes: Describe symptoms:_____ When did symptoms start:_____
Anxiety	□	□	If yes: Describe symptoms:_____ When did symptoms start:_____

Therapy History:

Please check the following services you have utilized:

	Current	Past	Provider	Dates
Counseling	□	□	_____	_____
Psychiatric services	□	□	_____	_____
Partial hospitalization	□	□	_____	_____
Case Management	□	□	_____	_____
Drug/alcohol	□	□	_____	_____
Residential treatment	□	□	_____	_____

Family Mental Health History: Please indicate any mental health problems in your family:

Family member with mental health issues: □ Father Problem: _____

□ Mother Problem: _____

□ Sibling Problem: _____

□ Other Relative Problem: _____

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____