The Northwest Catholic Counseling Center

Providing help, creating hope…

Adult Psychosocial History

Date______________________ Client ID___________
(office use only)

Please provide the following information. It will assist us in getting to know you and your concerns. It will be held to the same standards of confidentiality as an appointment.

Name ____
First M.I. Last

Address____

____
City State Zip

Birth date ___________/____________/____________

Home Phone:_________________________________
May we leave a message? ☐Yes ☐No
Do you prefer calling for appointment reminders? ☐Yes ☐No

Cell Phone: _________________________________
May we leave a message? ☐Yes ☐No
Do you prefer texting for appointment reminders? ☐Yes ☐No

Email: _____________________________________
May we email you? ☐Yes ☐No
Do you prefer emailing for appointment reminders? ☐Yes ☐No

Relationship Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Gender: ☐Female ☐Male ☐Transgender ☐Gender Neutral

Emergency contact-please list the name, telephone number and relationship _________________

____

Referred by ____

We would like to periodically send you newsletters and other information regarding the Center and its activities. Please check if you do not want to receive this information. ☐

8383 N.E. Sandy Boulevard, Suite 205 • Portland, Oregon 97220 • 503.253.0964
www.nwcounseling.org

Over please

Disability

Defined as substantially limiting movement, sensory, social, employment, or learning activities.
☐Yes ☐No ____

Ethnicity

☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐White
☐Multi-ethnic ____

Social Information

Please describe your primary support system (family, friends, support groups, church community, etc)

____

____

Do you identify as LGBTQ? ☐Yes ☐No

Education/Occupational Information

Are you currently employed? ☐Yes ☐No ☐On disability

If yes, name of current employer/position.______________________________________

Please indicate highest level of education.____________________

Degree, if applicable_________________

Are you happy at your current position? ____

Please list any work-related stressors.____

If unemployed, how long have you been unemployed? __________________________

Religious/Spiritual Information

Do you consider yourself to be a religious person? ☐Yes ☐No
Do you consider yourself to be a spiritual person? ☐Yes ☐No

If yes, what is your faith/religion/spiritual path?__________________________________

Office use only:
☐Entered in FM ☐Entered in TH

Name: ________________________________

Legal History

Are you currently or have you ever been involved in any legal proceedings (SSD, traffic, divorce, civil, criminal)?
If yes, please describe____

Are you preparing for any legal proceedings? ☐Yes ☐No If yes, please explain____________

____

Are you presently on probation or parole? ☐Yes ☐No If yes, please explain_______________

____

Mental Health History

Are you currently receiving any mental health treatment or prescribing services elsewhere?

☐Counseling: Name of counselor/agency: ____

☐Medications: Name of Prescriber: ____

Have you had previous counseling? ☐Yes ☐No

If yes, previous therapist's name ____

How long ago did you receive these services? _______________

Have you ever engaged in self-harming behavior? ☐Yes ☐No

Describe and when was last time: ____

Have you ever attempted suicide? ☐ Yes ☐ No When: _______________________________

Were you hospitalized for either self-harm or for an attempted suicide in the past? ☐ Yes ☐ No

What hospital: _____________________________________

In the last year, have you experienced any significant life changes or stressors (death of a loved one, divorce, loss of job, etc.)? ____
____

Have you experienced any traumatic events? ____

____

What coping strategies do you currently use and how effective are they?_______________

____

Over please ➜

What are your goals or concerns for therapy and/or medication management?
____

____

What do you consider to be your strengths?____________________________________

Family Mental Health History

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? **Check any that apply and list family member** (sibling, parent, uncle, etc).

☐ Depression ________________________
☐ Anxiety ________________________
☐ Schizophrenia ________________________
☐ Eating Disorder ________________________
☐ Trauma ________________________
☐ Bipolar Disorder ________________________
☐ Panic Attacks ________________________
☐ Alcohol/Substance Abuse ________________________
☐ Completed Suicides ________________________
☐ ADHD ________________________

Health Information

Allergies: (List any meds, foods, etc.) ____

____

How would you describe your physical health at present?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Primary Care Provider__________________________________Phone #__________________

Date of last physical: ____________________________

Please indicate if you experience now or in your history any of the following medical issues:

☐ Heart disease	☐ Seizures	☐ Pregnancy Issues
☐ Chronic Pain	☐ Diabetes	☐ Fibromyalgia
☐ Cancer	☐ Stroke	☐ Chronic Fatigue
☐ Thyroid Problems	☐ Hepatitis	☐ Urinary Tract Infections
☐ High Blood Sugar	☐ Migraines	☐ Binging/purging/food restriction
☐ Sleep Disturbances	☐ Premenstrual issues	☐ Unexplained weight fluctuations

Have you ever been hospitalized for any of these conditions and when: _________________________

____

Name: ________________________________

Please list all medications (including over-the counter/herbal remedies) and dosages.

Meds	Dosage
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

What do you do for physical activity:____

____

Substance Use

Do you use tobacco? ☐Yes ☐No How much per day: ____________________________

Do you use Caffeine? ☐Yes ☐No How much per day: ____________________________

Do you drink alcohol? ☐Yes ☐No How much per week: __________________________

Do you engage in recreational/street drugs? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

What kind?____

Describe any history with recreational/street drugs: _________________________________

If applicable, describe any treatment obtained for addiction:____________________________

____

Please check behaviors and symptoms that happen more often than you would like them to occur.

- ☐ Aggression
- ☐ Angry
- ☐ Concentration issues
- ☐ Crying spells
- ☐ Depressed Mood
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Elevated mood
- ☐ Excessive purchasing
- ☐ Exposure to traumatic event(s)
- ☐ Fatigue/low energy
- ☐ Fearful
- ☐ Gambling concerns
- ☐ Grief
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ Homicidal thoughts
- ☐ Hopelessness
- ☐ Indecisiveness
- ☐ Isolating from friends/family
- ☐ Jealousy
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Loss of interest in activities
- ☐ Memory impairment
- ☐ Inadequacy
- ☐ Insecurity
- ☐ Irritability
- ☐ Mood shifts
- ☐ Nightmares
- ☐ Obsessions
- ☐ Panic attacks
- ☐ Persistent urges or thoughts
- ☐ Physical discomfort
- ☐ Pornography concerns
- ☐ Racing thoughts
- ☐ Reckless or self-destructive
- ☐ Repetitive behaviors
- ☐ Restless or keyed up
- ☐ Revengeful
- ☐ Sadness
- ☐ Sexual addictions
- ☐ Sexual difficulties
- ☐ Shame/Guilt
- ☐ Shortness of breath
- ☐ Socially avoidant or isolating
- ☐ Stomachaches
- ☐ Suicidal thoughts
- ☐ Suspicious of others
- ☐ Tics
- ☐ Trembling
- ☐ Trauma
- ☐ Worrying excessively

☐ Other___________________________