The Northwest Catholic Counseling Center

Serving all regardless of faith or finances

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 ☐Other Pronouns: _____

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. ☐

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www.nwcounseling.org

Disability

Defined as substantially limiting movement, sensory, social, employment, or learning activities.

☐Yes ☐No _____

Ethnicity (Choose all that apply)

☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐White
☐Multi-Ethnic _____
☐Other _____
☐Prefer not to answer

Social Information

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

Do you identify as LGBTQ? ☐ Yes ☐ No

Education/Occupation Information:

Are you currently employed? ☐ Yes ☐ No

If yes, name of current employer/position:

Please indicate highest level of education:

Degree, if applicable:

Are you happy in 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/religious/spiritual path?

Office Use Only
☐ Entered in FM ☐ Entered in TH ☐ Scanned

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 when and the 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?

What are your goals or concerns for therapy?

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