

Kara Hoppe, MA, MFT
 Psychotherapy

CLIENT HISTORY

Name: _____

Date: ___/___/___

Current Symptoms Checklist:

Symptom & Severity (X if applicable)	Mild	Moderate	Severe	For how long?
Depressed Mood, Hopelessness				
Suicidal Thoughts				
Anxiety, Frequent Worry				
Anger, Hostility				
Violent acts				
Compulsive behaviors				
Concerns about sexuality				
Problems with sexual function				
Sleep problems				
Weight fluctuations				
Eating problems				
Communication problems				
Financial problems				
Employment difficulties				
Obsessive thoughts				
Grief				
Somatic complaints				
Panic attacks				

Substance Use	No	Yes	How often?	Substance Use	No	Yes	How often?
Alcohol				Sedatives			
Marijuana				Opiates			
Cocaine				Hallucinogens			
Methamphetamines				Stimulants			

- Have you ever been in therapy before? _____ When? _____
- How was the experience?

- Have you ever been hospitalized for a psychiatric illness or for physical reasons? _____ If yes, please say more _____
- Are you currently under the care of a psychiatrist? If yes, please provide their name: _____
- Are you currently taking any medications? If yes, please state which one(s): _____

- Has your substance use felt like it is/was a problem for you?

- Has anyone in your family struggled with mental illness?

- Are you an emotional trauma survivor?

- Are you sexual trauma survivor?

Relationships:

- Never been in a serious relationship Not currently in a relationship
 Currently in a serious relationship _____yrs in current relationship

Marital/partner status:

- single, never married/partnered separated for ___ years
 _____prior marriages/partnered (*self*) engaged for ___ months
 divorce in process ___ months _____prior marriages/partnered (*partner*)
 married/partnered for _____ years divorced for _____ years
 live-in for _____ years

Relationship satisfaction:

- very satisfied with relationship somewhat satisfied with relationship
 very dissatisfied with relationship satisfied with relationship
 dissatisfied with relationship

Briefly describe any significant issues in *intimate* relationships:

Family History:

	Present Entire Childhood	Present Part of Childhood	Not Present
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special circumstances in childhood:

Describe childhood family experience:

- | | |
|---|---|
| <input type="checkbox"/> outstanding home environment | <input type="checkbox"/> chaotic home environment |
| <input type="checkbox"/> experienced physical/verbal/sexual abuse | <input type="checkbox"/> normal home environment |
| <input type="checkbox"/> neglectful home environment | <input type="checkbox"/> witnessed physical/verbal/sexual abuse |

Parents:

Father living? Y/N Age: _____ Occupation: _____ Education: _____ General Health: _____
Mother living? Y/N Age: _____ Occupation: _____ Education: _____ General Health: _____

Parent's current marital status:

- | | | |
|--|---|---|
| <input type="checkbox"/> married to each other | <input type="checkbox"/> mother remarried _____ times | <input type="checkbox"/> father remarried _____ times |
| <input type="checkbox"/> separated from each other | <input type="checkbox"/> mother involved w/someone | <input type="checkbox"/> father involved w/someone |
| <input type="checkbox"/> divorced for _____ years | <input type="checkbox"/> mother widowed | <input type="checkbox"/> father widowed |

Socio-Economic History:

Social support system (*check all that apply*):

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> supportive network | <input type="checkbox"/> few friends | <input type="checkbox"/> substance-use-based friends |
| <input type="checkbox"/> distance from family of origin | | |

Employment:

- | | | |
|--|---|--|
| <input type="checkbox"/> employed and satisfied | <input type="checkbox"/> coworker conflicts | <input type="checkbox"/> disabled |
| <input type="checkbox"/> employed but dissatisfied | <input type="checkbox"/> supervisor conflicts | <input type="checkbox"/> unstable work history |
| <input type="checkbox"/> unemployed | | |

Legal history:

- | | | |
|--|---|--|
| <input type="checkbox"/> no legal problems | <input type="checkbox"/> lawsuits pending | <input type="checkbox"/> arrest(s) not substance-related |
| <input type="checkbox"/> arrest(s) substance-related | | |

Military history:

- | | |
|--|--|
| <input type="checkbox"/> never in military | <input type="checkbox"/> served in military- no incident |
| <input type="checkbox"/> served in military with incident: _____ | |

Cultural/Spiritual/Recreational History

Currently active in community/recreational activities?

- No Yes

Formerly active in community/recreational activities?

- No Yes

Currently engage in hobbies?

- No Yes

Currently participate in cultural/spiritual/religious activities?

- No Yes

Additional Information/Notes:

Client signature

____/____/____

Date