Integrative Counseling & Psychological Services, PC

Naperville Location:
616 West 5th Avenue, Suite B • Naperville, IL 60563
630.717.7771 *(office)* • **630.206.2003** *(fax)*

Deerfield Location:
440 Lake Cook Road, Building 1 • Deerfield, IL 60015
847.892.6000 *(office)* • **847.892.6151** *(fax)*

630.418.0280 *(emergency)* • **integrativecps@gmail.com** *(email)*

Confidential Adult Client History

(please print)

IDENTIFYING INFORMATION:

CLIENT NAME:______________________________ D.O.B.:__________ RACE: ______________ SEX:___________

ADDRESS:____ PHONE:______________________________

OTHERS IN HOUSE: Spouse/Partner _____ Children _____ Parents _____ Friend _____ Siblings _____ Others____________________

Referred By:____

PERSON COMPLETING THIS FORM *(if not the client)*:

Name: ____ Relationship to client: ______________________________

Check any of the following behaviors that have recently applied to the client:

___ Feeling sad/down
___ Too much energy
___ Decreased interest in activities
___ Being overly irritable
___ Decreased enjoyment
___ Feeling on top of the world
___ Significant weight change
___ Engaging in risky behavior
___ Change in sleeping patterns
___ Feeling anxious
___ Feeling restless, or slowed down
___ Feeling worried a lot
___ Feeling excessively tired
___ Panic attack(s)
___ Withdrawal, isolation

___ Excessive fears
___ Feeling worthless or guilty
___ Feeling judged by others
___ Decreased ability to concentrate
___ Feeling uncomfortable around others
___ Difficulty making decisions
___ Unpleasant thoughts about an event
___ Thoughts of death
___ Obsessions (thoughts you can't get rid of)
___ Suicide attempt
___ Thoughts of hurting self/others
___ Compulsions (doing things over & over)
___ Feeling overwhelmed

___ Change in eating patterns
___ Temper outbursts/Aggression
___ Agitation/ being upset
___ Relationship difficulties
___ Being overactive
___ Being impulsive
___ Losing things
___ Losing track of time
___ Being disorganized
___ Feeling disconnected from oneself
___ Having feelings of unreality
___ Seeing or hearing things others don't
___ Using drugs
___ Using cigarettes/alcohol (__ day/ week/ month)

HISTORY OF TREATMENT:

Has the client/family ever received counseling for emotional or substance abuse problems? __________ Yes __________ No

Explain if yes:____

____

Problem treated for: ____

Provider: ____ When treated?____________________

Problem treated for: ____

Provider: ____ When treated?____________________

FAMILY HISTORY

Spouse/Partner *(or significant other's)* name: ____

Age: _________ Health: ____________________________ Occupation: ______________________________

Home phone # ____________________ Work phone # ______________________ Cell phone # ______________________

Children's name and ages: ____

What should the therapist know about family members? ____

____

What is the client's family history of mental health treatment/concerns? ______________________________

____

Any significant individuals *(other than family)* in the home or client's background? ______________________

____

Significant life events *(include births, deaths, moves, traumatic events)*: ______________________________

____

____

RELATIONSHIP HISTORY

Currently married or partnered? ___Yes ___ No *(Date if yes)* ______________________

Previously married or partnered? ___ Yes ___ No If yes, please give name of ex-spouse/partner, date(s) of previous marriage(s)/partnership(s):

____

History of domestic problems (current or past): ____

____

Anything your therapist should know about children/stepchildren?: ______________________________________

____

MEDICAL HISTORY

Are there any medical treatment(s) that the client is currently receiving or has recently received? ________ Yes _________ No

Explain if yes: ____

____

Please list ALL medications: ____

____

Please list any significant medical problems for other members (parents, siblings, aunts, uncles, children, etc.) of the family: _______________

____

____

Has the client ever been physically or sexually abused? ________ Yes ______ No

Explain if yes: ____

____

EDUCATION

Current school or last school attended: ____

Grade level: _________ Academic Functioning (grades): ____

Did the client ever receive special services in school? ____

Academic problems or special needs: ____

VOCATIONAL:

Present job: ____ Employer: ________________________________

Length of time at present job: ________________ Work history: ____

____

LEGAL HISTORY:

Are there any legal charges pending? _________ Yes __________ No Has the client ever been arrested? _________ Yes _________ No

Specify: ____

____

Signature: ____ Date: ____________________