

**PRAIRIE COUNSELING SERVICES
CLIENT HISTORY FORM**

Client _____ Birth Date: _____

HEALTH HISTORY

Does the client or any member of his/her family of origin have a history of any of the following?

_____ Mental/Emotional Illness _____ Alcohol/Substance Abuse _____ Developmental Disabilities

If so, Please explain: _____

Has the client received treatment in the past for mental/emotional health problems? _____ Alcohol/Substance Abuse? _____

If yes, please give dates and location: _____

Does the client or close family members have a history of suicide attempts or of violence such that there have been efforts to injure self or another? _____ Yes _____ No

Please list any mental health/substance abuse hospitalizations and any significant traumatic events:

<u>Event/Hospitalization</u>	<u>Age Occurred</u>	<u>Continuing Problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Approximate date of client's last physical exam: _____

Client's physical health is: Excellent _____ Good _____ Fair _____ Poor _____

Client's primary physician or clinic: _____

Current prescribed medications: _____

Prescribing physician(s): _____

ANY ALLERGIES: _____

OCCUPATIONAL HISTORY:

Present work: _____ How long? _____ Employer: _____

Prior major position or work (list jobs, time held): _____

Occupational problems, if any: _____

MILITARY HISTORY:

Branch of service: _____ Work: _____ From _____ to _____

Problems, if any: _____

SOCIAL INTERESTS:

Hobbies, avocations, special interests: _____

EDUCATIONAL HISTORY:

Years of school completed: _____ Degrees: _____ Major: _____

School problems, if any: _____

Client's strengths: _____

Client's weakness: _____

Client's or parent/guardian's concerns/reason(s) for seeking treatment:

How long have these concerns been present: _____

IF CLIENT IS OVER 18, PLEASE SIGN AT BOTTOM. IF CLIENT IS UNDER 18, PLEASE CONTINUE

Any problems with peers/siblings? _____

Is child in a blended family? _____ A step-child? _____

Who is step-parent? _____ How many other children at home? _____

How many other children not at home? _____

Any known history of physical, emotional or sexual abuse? _____

Any development/behavioral/educational concerns not listed above? _____

Client (over 14) Signature

Date

Parent or Guardian Signature

Date