Center for Tranquil Transitions, LLC

Client Name: ______________________ DOB: __________ Sex: _______ Date Completed: ______
Name of person Completing this form and relationship to client: ________________________________

Reason for seeking counseling:

Problems and Symptoms	**Past**	**Present**	**Not Applicable**	**Explanation**
Change of Appetite	☐	☐	☐	
Bingeing/purging food	☐	☐	☐	
Weight loss/gain	☐	☐	☐	
Insomnia/hypersomia	☐	☐	☐	
Withdrawn	☐	☐	☐	
Depression	☐	☐	☐	
Mood Swings	☐	☐	☐	
Anxiety	☐	☐	☐	
Obsessive Thoughts	☐	☐	☐	
Compulsive Behaviors	☐	☐	☐	
Anger Management	☐	☐	☐	
Cruelty to Animals	☐	☐	☐	
Poor Memory	☐	☐	☐	
Processing Difficulty	☐	☐	☐	
Fire setting	☐	☐	☐	
Bladder Control	☐	☐	☐	
Bowel Control	☐	☐	☐	
Aggression	☐	☐	☐	
Lying	☐	☐	☐	
Stealing	☐	☐	☐	
Sexual Acting Out	☐	☐	☐	
Sexual Dysfunction	☐	☐	☐	
Nightmares/night terrors	☐	☐	☐	
Vivid dreams	☐	☐	☐	
Fears	☐	☐	☐	
Unexplained physical complaints	☐	☐	☐	
Abuse/neglect	☐	☐	☐	
Grief/loss	☐	☐	☐	
Stress	☐	☐	☐	
Flash Backs	☐	☐	☐	
Financial	☐	☐	☐	
Addictive Behavior	☐	☐	☐	
Impulsivity	☐	☐	☐	
Hyperactivity	☐	☐	☐	
Lethargic	☐	☐	☐	
Poor Concentration	☐	☐	☐	
Short Attention Span	☐	☐	☐	
Poor Family Relations	☐	☐	☐	
Poor Relations in the Workplace	☐	☐	☐	
Poor Relations with Peers	☐	☐	☐	
Hallucinations/delusions	☐	☐	☐	
Difficulty with Authority	☐	☐	☐	
Spiritual Issues	☐	☐	☐	
Feeling inadequate/Low self worth	☐	☐	☐	
Other	☐	☐	☐	

Mental Health History: (Past out patient services and hospitalizations, include dates)
____
____
How did it help? ____
What was your diagnosis (es)? ____
Have you ever experienced suicidal/homicidal ideations? Yes/No Intentions? Yes/No
If yes, please explain: ____
____
Are you willing to sign a release of information for previous mental health providers? Yes/No

Significant Relationships (Circle One): Married Divorced Widowed Significant Other….Single
If married/divorced how many times? _________ How long married/divorced? _________
Name children and ages: ____
On a scale of 1-10, 10 being very satisfied, rate level of satisfaction with current relationship: ________

Legal Issues: (List any past & present legal issues: i.e., arrests, convictions, bankruptcy, divorce etc. include dates) ____
____

Abuse History (has client been victim of any type of abuse?)**:**
Physical abuse ☐ Yes ☐ No Emotional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No
Domestic Violence☐ Yes ☐ No Abandonment ☐ Yes ☐ No Neglect ☐ Yes ☐ No

Age(s) at time of abuse: ______________________ Treatment received: ______________________
Who was perpetrator? ____
Reported to Authorities? _____________________ Finding/disposition: ______________________

Did client witness any types of abuse listed above: ☐ Yes ☐ No
If yes, which type of abuse? ____
Who was the victim? ______________________________ Who was the perpetrator? ___________
Has client been the perpetrator of any abuse? ☐ Yes ☐ No Who was the victim? _______________
If yes, which type of abuse? ____

Addiction/Substance Use History (If you need more space use back of page)**:**

Substance	Yes	No	Substance	Yes	No	Substance	Yes	No
Alcohol	☐	☐	Pain Pills	☐	☐	Marijuana	☐	☐
Tranquilizers	☐	☐	Stimulants	☐	☐	Inhalants	☐	☐
Sleeping Pills	☐	☐	Narcotics	☐	☐	Food	☐	☐
Hallucinogens	☐	☐	Heroin/Meth	☐	☐	Sex	☐	☐
Gambling	☐	☐	Pornography	☐	☐	Other	☐	☐

Drug of preference: ___________ How long used? __________ Last used? ______________
Treatment program: __________ When? ________ How long? ________ How long clean/sober? ______

Medical History (If you need more space use back of page)**:**
List any major accidents, illnesses, operations with date of occurrence: ___________________________
____
____
List date and type of any head injuries or seizures: _______________________________________
____
List current medications and reason prescribed: ____
____
List any allergies to medications: ____
List any sexually transmitted diseases: ____

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Physician:
Are you currently under a physician's care? ______________________________
Names of Physicians/Specialists who are treating you: ______________________________
____
____
____

Education:
Highest grade completed: ____________ Graduated/degree: ____________
Any difficulty learning to Read: ______ Write: _______ Math: __________
Did you ever repeat a grade? Yes/No For what reason: ____________
Favorite subject: ____________ Most accomplished subject: ____________
Circle One:
I learn best by: seeing it done reading about it hearing about it

Occupation:
Current occupation/vocation: ____________ How long: ____________

On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? ______
Please describe any difficulties you are having concerning your occupation: ____________
____
____

Social Relationships:
How frequently do you socialize with friends? ______________________________
How frequently do you socialize with extended family? ______________________________
What kinds of activities do you do when you get together? ______________________________
____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: _____
Rate your satisfaction with extended family relationships: _______
Who do you feel is "on your side" in life? ______________________________
Are there any people in your life you can talk to about your problems? ____________
Please describe any difficulties you are having socially: ______________________________
____

Family History (Please list those family members with a <u>history of mental illness, learning disabilities, mental retardation or addictions</u>) (If you need more space use back of page)
Children: ______________________________
____
Parents: ______________________________
____
Siblings: ______________________________
____
____
Maternal Grandparents: ______________________________
____
Paternal Grandparents: ______________________________
____
Maternal Aunts and Uncles: ______________________________
____
Paternal Aunts and Uncles: ______________________________
____

Developmental History:
Prenatal health issues:
____
____
Birth Trauma (C-section, birth injuries, complications):
____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding:

Sexual History:
Age at first sexual experience? ____
On a scale of 1-10, 10 being very satisfied, how would you rate your sexual experiences: ______________
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your sexual self-image: __________
On a scale of 1-10, 10 being very satisfied, how satisfied are you with the frequency of sex: ____________
Please describe any sexual difficulties you are having: ____
____
____

Nutrition:
Do you eat a balanced diet by the food pyramid standard? ____
How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)__________________
How much tobacco do you smoke/chew daily? ____
How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None
How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None
Energy level: lethargic low average high hyperactive
How would you rate your current health: poor fair good excellent
List any food allergies you have: ____
How would you rate your weight/height/body fat ratio: poor fair good excellent
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image
Please describe any difficulties you are having with health, nutrition, body image: ____________________
____
____
Describe your exercise routine (what you do, how often you do it) __________________________________
____
____

Spiritual History:
Do you believe in God? Yes/No
Do you have a religious affiliation with which you are active? Yes/No
Do you use any particular religious writings (Bible, Qur'an etc) to find truth for your life?Yes/No
How does your faith help you to cope with life's problems? _______________________________________
____

Goals for Counseling:

What three things would you like to change by participating in counseling?
1. ____
2. ____
3. ____

How long do you think it will take to make these changes? ___________________________________
____
____

What do you think it will require on your part to make these changes? ____________________________
____
____

How will you know when you have accomplished your goals for counseling? _______________________
____
____

What else do you think is important for your counselor to know about you? _______________________
____
____
____
____
____
____
____

Emergency Contact:
Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)
____
____

Client Signature: ____ Date: ________________

Primary Caregiver's signature: __________________________________ Date _________________

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