Client History Form

The information on this form is confidential. We will not share it with anyone outside of Shine A Light Counseling Center without your written consent, except in case of emergency or when required by law.

Basic Information
Name:
Birthdate: Age:
Medi-Cal ID#:
Phone: Email:
Home address:
How do you prefer we contact you? ____ Call ____ Text ____ Email
Phone messages: Is it ok for us to identify ourselves as from Shine A Light? ____ Y ____ N
What race do you identify with: What gender do you identify with:
Relationship status: Number of children:
Monthly household income:

Safety Issues
Have you ever attempted suicide? ____ Yes ____ No
If yes, what are the dates:
Have you had suicidal ideation in the last year? ____ Yes ____ No
Do you currently think about suicide? ____ Yes ____ No
If yes, do you have a plan? ____ Yes ____ No
If yes, do you have the means? ____ Yes ____ No

Reason for Seeking Treatment

Please briefly explain the history of the issues you are seeking therapy for (symptoms, onset, duration, frequency):

Your goals in relation to this therapy:

Which of the following affect you? (check all that apply)

- ❑ Anxiety
- ❑ Depression
- ❑ Anger
- ❑ Grief
- ❑ Loneliness
- ❑ Relationship conflict
- ❑ Loss of intimacy
- ❑ Infidelity
- ❑ Sexual problems
- ❑ Chronic pain
- ❑ Problem drinking
- ❑ Addiction
- ❑ Anorexia
- ❑ Bulimia
- ❑ Overeating
- ❑ Impulse control
- ❑ Career Issues
- ❑ Sleep problems
- ❑ Difficulty concentrating
- ❑ Fatigue
- ❑ Panic attacks
- ❑ phobias
- ❑ PTSD
- ❑ emotional trauma
- ❑ LGBTQ issues
- ❑ Parenting Issues
- ❑ Women's issues
- ❑ Men's issues
- ❑ Mid-life crisis
- ❑ Alternative relationships
- ❑ Divorce
- ❑ Co-parenting
- ❑ Step-parenting
- ❑ High stress

❑ Poor communication

❑ Financial problems

Which statements feel true for you? (check all that apply)

❑ I feel tense most of the time

❑ I have a lot of physical problems that can't be explained

❑ I worry most of the time

❑ I have compulsive behaviors (like checking door locks)

❑ I have nightmares or flashbacks

❑ I feel short of breath or shakiness

❑ I avoid social situations because of fear

❑ I don't leave the house unless I have to

❑ I think about dying or killing myself

❑ I can't concentrate on anything very well

❑ I no longer have interest in things that used to interest me

❑ I feel hopeless about the future

❑ I have trouble making decisions

❑ I feel sluggish and/or restless

❑ I am gaining or losing weight without trying to

❑ I have trouble falling asleep

❑ I wake up early and can't go back to sleep

❑ I am sleeping too much

❑ I can't get enough sleep

❑ I don't seem to need sleep much anymore

❑ I feel irritable

❑ I am arguing with people a lot

❑ I have spontaneous urges to cry

❑ I have a lot more energy now than usual

❑ I can talk and talk when I get wound up

Psychiatric History

Have you ever been admitted to a psychiatric hospital? If so, please briefly explain circumstances and provide dates and diagnoses (to the best of your recollection):

Have you ever seen a psychotherapist before? If so, please provide dates and a brief explanation of the focus of your therapy:

Trauma History

What hardships affected you or your family when you were a child?

What hardships affect you or your family now?

Family Psychiatric History

Please list any mental health or substance use related issues of family members

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sibling:

Sibling:

Medical Conditions and History

What medical issues are you dealing with, or have been significant in your past?:

What medications are you currently taking (including psychiatric)?:

What medications have you been on previously (including psychiatric)?:

Substance Use History

Have you ever been treated for substance use? If so, what were the dates?

What recreational substances do you use?

- ❏ Tobacco
- ❏ Marijuana
- ❏ Alcohol
- ❏ Pain killers
- ❏ Ecstasy
- ❏ Hallucinogens
- ❏ Cocaine
- ❏ Methamphetamine
- ❏ Heroin
- ❏ Tranquilizers
- ❏ Stimulants
- ❏ Other:_____

In what amount and frequency do you use any substances?

Family and Social History

Who are you currently living with?

Are there any current or past issues with your family relationships?

Would you like your family to be involved in your therapy in any way? If yes, explain:

Are there any current or past issues with your social relationships?

Do you identify with a religion or spiritual practice?

Education & Occupation

What is the highest level of education you have completed?

- ❏ Middle School
- ❏ High school
- ❏ Some college
- ❏ Bachelor's Degree
- ❏ Graduate Degree
- ❏ Doctorate

Current employment status:

- ❏ Unemployed
- ❏ Full time employee
- ❏ Part time employee
- ❏ Full time student
- ❏ Part time student

Where are you currently employed or attending school?

Have you ever been suspended or expelled from school or fired from a job?

Legal History

Have you ever been charged with a crime? If so, briefly describe:

Have you ever been incarcerated? If so, briefly describe:

Are you now, or might soon be, involved in a lawsuit? If so, briefly describe:

Strengths and Limitations

Please identify your top three strengths:

Please identify your top three limitations:

Additional Information

Is there anything else you would like your counselor to know about you?

Thank you for your information. We look forward to working with you!