Minnesota Relational Counseling

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Personal History

Please bring this completed form to your first appointment.

Please provide the following information for your record. Leave blank any question you would rather not answer. All information given by you is confidential unless released by written consent or as otherwise required by law.

Today's Date ___________________

Contact Information

Client's Name ____
(Last) (First) (M)

Address_________________________________City________________________State_____Zip_______

Phone Home ______________________ Work _________________________Cell___________________

E-mail ____

I give my permission to be called at: Home Yes/No Cell Yes/No Work Yes/No

I give my permission to be emailed: Yes/No

Special instructions____

I understand that caller ID may disclose the therapist's name to others and that email may not be confidential.

Please initial _______

Emergency contact ____

Relationship____

Phone ____

Background Information

Birth date ___________________ Age______ Gender ________________

Marital Status: (check all that apply)

___Single ___Married ___Partnered ___Separated ___ Divorced ___ Annulment ___Widowed

Education**:** Check all completed.

___ Elementary ___ Junior High ___ High School

___ Vocational Area of study/Degree ____

___ College Area of study/Degree ____

___ Graduate/Professional School Area of study/Degree ____________________________

Occupation__________________________________ Employer________________ How many years? ____

Ethnic Background/Concerns ____

Religious affiliations/spiritual involvements ____

____

Hobbies/Interests____

Health History

Current Physical Health ___Excellent ___Good ___Fair ___Poor
Current Health Problems ______________________________
Chronic Health Problems______________________________
Recent significant weight gain or loss. Yes/No Describe ______________________________
Current Medications/Reasons Prescribed ______________________________
____
Regular Physician______________________________
Date of last physical exam ___________Results ______________________________
Previous Therapy Yes/No Time frame ______________ Psychotherapist______________________________
Issues addressed in previous therapy______________________________
____
How was this helpful?______________________________
Disruptive or traumatic events (such as abuse, injury, accident, illness, job loss, death of loved one, other losses, bullying or relational aggression) ______________________________
____
____

Chemical use (Alcohol, drugs, tobacco, caffeine)

Use	Type	Quantity	Frequency	Date Started (If applicable)	Date Ended (If applicable)
Alcohol					
Drugs					
Tobacco					
Caffeine					

Have others expressed concern about your chemical use? Yes/No
Are you concerned about your current chemical use? Yes/No
Have there been any undesirable results of your chemical use? Yes/No
(such as low job or school performance, physical/health problems, relationship problems, DUI's, legal…)
If yes, describe______________________________
Previous treatment Yes/No If yes, where? ______________________________
Are you currently attending a self-help group or support group? Yes/No
Name of group ______________________________
Do you now use alcohol/drugs for: ___social recreation ___get to sleep ___escape ___reduce physical discomfort ___reduce worry

Family History

Current Spouse/Partner

Name	Age	Occupation	Physical/Emotional/Mental Health Concerns

Years married/together _________

Former Spouse/Partner

Name	Age	Occupation	Physical/Emotional/Mental Health Concerns

Years married/together __________ Together from _________ to ________ (years)

Child(ren)

Name	Age	Grade/Occupation	Physical/Emotional/Mental Health Concerns

Parents/Step-parents

Name	Age	Occupation	Physical/Emotional/Mental Health Concerns

Siblings --biological, half, step

Name	Age	Occupation	Physical/Emotional/Mental Health Concerns

Other Significant Family Members or Relationships

Name	Age	Relationship	Physical/Emotional/Mental Health Concerns

Current Concerns

What is the current problem for which you are seeking help?

____
____
____
____
____
____

What abilities or skills do you have that might help with this problem?
(For example, intelligence, ability to honestly look at myself, curiosity about myself, creativity, flexibility, ability to relax, ability to communicate my thoughts or feelings or wants to others, etc.)

____
____
____

Is there anything else about you or your situation that is important to know?

____
____
____

How did you hear about MN Relational Counseling?

Referral__________________________ Website_____ Other_____________________________

Form Completed by __________________________________ Relationship to client _____________________

Signature ____ Date ___________________________________