



Counseling for Wellness, L.L.P.

Background Information Form

This form is to be completed prior to your first visit at Counseling for Wellness. Answer all questions to the best of your ability. Bring this form and any questions you have with you to your first appointment.

DATE: ___ / ___ / _____

NAME: _____
(First) (M.I.) (Last)

ADDRESS: _____
Number Street

City State Zip Code

PHONE: Work: (____) ____ - _____ Is it ok to call at work? Yes No
Home: (____) ____ - _____ Is it ok to leave a message at home? Yes No
Cell: (____) ____ - _____

AGE: _____ DOB: ___ / ___ / _____ SS#: _____ - _____ - _____

How did you learn about Counseling for Wellness?

Phone book Friend or family member referred Physician Provider List
Human Resources Website Other, please specify: _____

Who would you like us to notify in case of emergency?

Person's Name: _____ Relationship to you: _____
Phone: (____) ____ - _____ Cell phone: (____) ____ - _____

Employment/Educational Background

Are you currently employed? Yes No Where? _____

How long have you worked there? _____ Years

What do you do there? _____

If you are a student, name of school: _____

Highest level of Education: _____

Grade Average: _____ Major: _____

Any problems related to school? _____

Military Service? Yes No

Branch: _____ Dates of service ___ / ___ / _____ to ___ / ___ / _____

Type of discharge: _____

Do you have any religious or spiritual affiliations? Please explain:

Do you have any pets? Yes No Pet's name and type: _____

What are your hobbies, interests, or activities (e.g. sewing, sports, yoga):

Physical and Mental Health History

Do you have any current health/medical problems, including allergies? Yes No Please explain:

Are you under the care of a physician? Yes No

Name of Physician: _____

Address: _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____

History of major illnesses, surgeries, accidents, or operations:

Are you taking any prescription medication? Yes No

If yes, please give the name, dose and reason for medication:

Are you currently seeing another mental health professional? Yes No

Name of Provider: _____

Address: _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____

History of mental health problems for self or family:

Have you ever been prescribed medication for a mental health issue? Yes No

If yes, please give the name, dose, how long you took the medication for, when and why you stopped, and the reason for medication:

Have you been in counseling before? Yes No

If yes, please indicate when, where, with whom you met, how long you met for, why you started and why you stopped:

Social history/family of origin history:

Where were you born? _____

Raised? _____

Where are you in the birth order? _____

What are the sex and age of your siblings? _____

What is your relationship like with your siblings?

What did/do your parents do for a living? _____

What is your earliest memory of your mother? _____

What is a pleasant memory of your mother? _____

What is a disturbing memory of your mother? _____

When was a time you were angry with your mother? _____

How did you deal with your emotions regarding your mother? _____

List five words that describe your relationship with your mother during childhood:

What is your earliest memory of your father? _____

What is a pleasant memory of your father? _____

What is a disturbing memory of your father? _____

When was a time you were angry with your father? _____

How did you deal with your emotions regarding your father? _____

List five words that describe your relationship with your father during childhood:

Briefly describe the relationship between your mother and father:

What was it like growing up in your family? What did you do?

Are there any substance use issues in your family? For example alcohol or drug use.

Was there any physical, sexual, verbal, or emotional abuse in your family?

Marital/Relational history

Are you currently married? Yes No

How old were you at time(s) of marriage(s)? _____

Have you been married previously? Yes No Number of marriages: _____

Do you have any children? Yes No If yes, how many _____

Names and ages of children. Please indicate if the child is from a previous marriage.

What is your current spouse's occupation? _____

How do you manage money in your relationship?

Dates and reasons for breakups/separations/divorces?

Other significant relationships from your past?

Sexual concerns? For example: physical difficulties having or enjoying sexual intercourse, a decrease in sexual desire, unsatisfied sexually, etc.

Significant life events

Have you had any significant losses? Please explain:

Any significant shifts/transitions/changes in your life? Please explain:

Legal History:

Any past or current involvement with the legal system? Yes No

If yes, indicate dates of charges, arrests, or incarcerations:

History of children services investigations? Yes No

If yes, please indicate dates, the cause for investigations, and outcomes:

Alcohol and drug use history

Have you ever consumed alcohol? Yes No

Have you ever used other substances? Yes No

If yes: What is your drink/substance of choice: _____

How much do you drink/use substance in a typical week (1 drink= 12oz. beer, 6oz. glass of wine, OR 1oz. liquer): _____/week

When did you first drink/use substance: _____

Have you ever increased or decreased your use? When? How much? _____

Do you still drink/use this substance? Yes No

If no, when and how did you stop? _____

Do you use tobacco? Yes No

Please indicate type, how long you have used, and if you have tried to quit: _____

Have you had any problems at work or school because of alcohol or substance use? Yes No

If yes, please explain: _____

Have you had any problems with friends or family because of your alcohol or substance use?

Yes No

If yes, please explain: _____

Have you ever had any alcohol/substance use treatment? Yes No

If yes, please specify where and when you received treatment (also include 12-step work):

Is there any family history of alcohol or substance use or abuse? Yes No

If yes, please explain who in your family and how this may have impacted you: _____

Memory and Sensory Concerns

Do you ever forget things such as where you are or what time it is? Yes No

Do you ever feel like things are “unreal” or that you are removed from reality? Yes No

Has there been a time that you saw or heard something that no one else could? Yes No

Have you ever had a lot of energy when you could go for days without sleep or rest? Yes No

Do you ever worry that people are out to get you or hurt you in some way? Yes No

Do you ever have problems with sleeping (for example: problems falling or staying asleep or waking up earlier than you want)? Yes No

If yes, please describe:

Have you been able to maintain a health body weight? Yes No

Please explain: _____

Strengths

What motivates you?

Who does your support system include?

What are your strengths?

Current Concerns

What is/are the personal problem(s) that brings you to counseling?

Describe the problem(s) and your attempts to resolve it/them:

What is/are the problem(s) in your relationship?

If a miracle were to occur and all your problems were resolved, what would your life and relationships look like?

What are some of your goals for counseling?
