

# Waterfalls Counseling

## CLINICAL HISTORY REPORT

<b>DEMOGRAPHICS</b>	<b>Date:</b> _____
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Client Name: \_\_\_\_\_ Client Number: \_\_\_\_\_

Client Address: \_\_\_\_\_

Parent(s)/Guardian(s) Name(s): \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Okay to leave a message? \_\_\_\_\_

Home #: \_\_\_\_\_ Yes No Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Work #: \_\_\_\_\_ Yes No Age: \_\_\_\_\_

Cell #: \_\_\_\_\_ Yes No Gender: \_\_\_\_\_

<b>PRESENTING PROBLEMS</b>	<b>Duration (Months)</b>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

<b>CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms <u>currently</u> present)</b>
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**None** = This symptom not present at this time      **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning  
**Moderate** = Significant impact on quality of life and /or day-to-day functioning      **Severe** = Profound impact on quality of life

	None	Mild	Mod	Sev		None	Mild	Mod	Sev	None	Mild	Mod	Sev	
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	related medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>GOALS FOR COUNSELING</b>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## DEVELOPMENTAL HISTORY (required information under age 18)

Delayed Development or Long Term effects from events: check normal or check description and describe effect

- Prenatal/Perinatal Events:     Normal     Description    \_\_\_\_\_
- Physical:     Normal     Description    \_\_\_\_\_
- Psychological:     Normal     Description    \_\_\_\_\_
- Social:     Normal     Description    \_\_\_\_\_
- Intellectual:     Normal     Description    \_\_\_\_\_
- Academic/Educational:     Normal     Description    \_\_\_\_\_
- Sexual Abuse History     Normal     Description    \_\_\_\_\_
- Physical Abuse History     Normal     Description    \_\_\_\_\_
- Trauma Related History     Normal     Description    \_\_\_\_\_

## FAMILY HISTORY

**FAMILY OF ORIGIN:** (check all that apply)

**Present during childhood:**

- |                 | Present<br>entire<br>childhood | Present<br>part of<br>childhood | Not<br>present<br>at all |
|-----------------|--------------------------------|---------------------------------|--------------------------|
| mother          | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| father          | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| stepmother      | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| stepfather      | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| brother(s)      | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| sister(s)       | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| other (specify) | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| _____           |                                |                                 |                          |

**Parents current marital status:**

- married to each other
- separated for \_\_\_\_\_ years
- divorced for \_\_\_\_\_ years
- mother remarried \_\_\_\_\_ times
- father remarried \_\_\_\_\_ times
- mother involved with someone
- father involved with someone
- mother deceased for \_\_\_\_\_ years
- Age of client at mother's death \_\_\_\_\_
- father deceased for \_\_\_\_\_ years
- Age of client at father's death \_\_\_\_\_

**Describe parents:**

- | <b>Father</b>        | <b>Mother</b> |
|----------------------|---------------|
| full name _____      | _____         |
| occupation _____     | _____         |
| education _____      | _____         |
| general health _____ | _____         |
- Describe childhood family experience:**
- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse toward others
- experienced physical/verbal/sexual abuse from others

Age of emancipation from home: \_\_\_\_\_ Circumstances: \_\_\_\_\_

Special circumstances in childhood: \_\_\_\_\_

**Has any family member:** (check and describe all that apply)

- received outpatient psychotherapy? Who/Why: \_\_\_\_\_
- \_\_\_\_\_
- received inpatient treatment for a psychiatric, emotional or substance use disorder? Who/Why: \_\_\_\_\_
- \_\_\_\_\_
- had a history of alcohol/substance abuse? Who/What: \_\_\_\_\_
- \_\_\_\_\_

### IMMEDIATE FAMILY:

**Marital status:**

- single, never married
- engaged \_\_\_\_\_ months
- married for \_\_\_\_\_ years
- divorced for \_\_\_\_\_ years
- separated for \_\_\_\_\_ years
- divorce in process \_\_\_\_\_ months
- live-in for \_\_\_\_\_ years
- prior marriages (partner)

**Relationship satisfaction:**

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied w relationship
- dissatisfied with relationship
- very dissatisfied with relationship

**List all persons currently living in patient's household:**

Name	Age	Sex	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Intimate relationship:**

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

**List children not living in the same household as client: Name/Age/Sex/Frequency of contact**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## FAMILY HISTORY (continued)

Describe any past or current significant issues in intimate relationships: \_\_\_\_\_

Describe any past or current significant issues in other immediate family relationships: \_\_\_\_\_

## MEDICAL HISTORY

Describe current physical health:  Good  Fair  Poor Name of primary care physician: \_\_\_\_\_

Address/Telephone of Family Physician/PCP: \_\_\_\_\_

Date last seen: \_\_\_\_\_  release obtained  release refused by client

Current Medications/Dosages: (prescription/over the counter/herbal supplements): \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Name and Contact Information of Psychiatrist (if applicable): \_\_\_\_\_

Date last seen: \_\_\_\_\_  release obtained  release refused by client

Serious or long term effects of Illnesses, Surgeries, Injuries, and/or Hospitalizations:

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason/Effects \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason/Effects \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason/Effects \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason/Effects \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason/Effects \_\_\_\_\_

## MENTAL HEALTH HISTORY

Prior outpatient psychotherapy?  No  Yes

Provider Name: \_\_\_\_\_ Dates seen: \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Reason: \_\_\_\_\_  release obtained  release refused by client

Provider Name: \_\_\_\_\_ Dates seen: \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Reason: \_\_\_\_\_  release obtained  release refused by client

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?  No  Yes

Provider Name: \_\_\_\_\_ Dates seen: \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Reason: \_\_\_\_\_  release obtained  release refused by client

Provider Name: \_\_\_\_\_ Dates seen: \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Reason: \_\_\_\_\_  release obtained  release refused by client

Current Treatment?  No  Yes

Provider Name: \_\_\_\_\_ Dates seen: \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Reason: \_\_\_\_\_  release obtained  release refused by client

## SUBSTANCE ASSESSMENT (over age 12)

### History of Use:

Past Alcohol:  No  Yes Description: Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_  
Past Drugs:  No  Yes Description: Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_  
Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current Use:

Alcohol:  No  Yes Description: Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_  
Drugs:  No  Yes Description: Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_  
Description \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Alcohol/Drug Treatment:

Inpatient:  No  Yes When/Where: \_\_\_\_\_  
Outpatient:  No  Yes When/Where: \_\_\_\_\_  
\_\_\_\_\_

## SOCIO-ECONOMIC HISTORY

### Current Supportive Relationships: check and describe all that apply

Siblings: \_\_\_\_\_  
Parents: \_\_\_\_\_  
Friendships: \_\_\_\_\_

**Sexual Orientation:**  heterosexual  homosexual  bisexual

### Cultural/Spiritual/Recreational History:

Cultural identity (e.g. ethnicity, religion): \_\_\_\_\_  
Any cultural or religious issues that contribute to current problems: \_\_\_\_\_  
\_\_\_\_\_

Currently active in community/church/recreational activities?  No  Yes Description: \_\_\_\_\_

Formerly active in community/church/recreational activities?  No  Yes Description: \_\_\_\_\_

Currently engaged in hobbies?  No  Yes Description: \_\_\_\_\_

Importance of Faith in Counseling: \_\_\_\_\_

<b>Living Situation:</b>	<input type="checkbox"/> housing adequate	<input type="checkbox"/> housing overcrowded	<input type="checkbox"/> dependent on others for housing	<input type="checkbox"/> homeless
	<input type="checkbox"/> housing dangerous/deteriorating	<input type="checkbox"/> living companions dysfunctional		
<b>Employment:</b>	<input type="checkbox"/> employed and satisfied	<input type="checkbox"/> employed but dissatisfied	<input type="checkbox"/> unemployed	
	<input type="checkbox"/> coworker conflicts	<input type="checkbox"/> supervisor conflicts	<input type="checkbox"/> disabled _____	
	<input type="checkbox"/> student	<input type="checkbox"/> unstable work history		
<b>Education:</b>	<input type="checkbox"/> grades 1 - 8	<input type="checkbox"/> some college	<input type="checkbox"/> vocational or tech degree	
	<input type="checkbox"/> grades 9 - 12	<input type="checkbox"/> college graduate		
	<input type="checkbox"/> high school graduate	<input type="checkbox"/> post graduate degree		
<b>Financial Situation:</b>	<input type="checkbox"/> no current financial problems	<input type="checkbox"/> impulsive spending	<input type="checkbox"/> relationship conflicts over finances	
	<input type="checkbox"/> large indebtedness	<input type="checkbox"/> poverty or below poverty income		
<b>Military History:</b>	<input type="checkbox"/> never in military	<input type="checkbox"/> served in military - no incident	<input type="checkbox"/> served in military - <u>with</u> incident, describe _____	
<b>Legal History:</b>	<input type="checkbox"/> no legal problems	<input type="checkbox"/> now on probation/parole	<input type="checkbox"/> jail/prison _____ time(s), total time served _____	
	<input type="checkbox"/> arrest(s) not substance related	<input type="checkbox"/> arrest(s) substance related	<input type="checkbox"/> description of last legal difficulty: _____	
	<input type="checkbox"/> court ordered this treatment			