In Tandem Counseling

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Date: _____

Client Name: _____ DOB _____

How did you learn about my services?_____

Gender: Male / Female / Non-binary_____ / Preferred Pronouns _____

What race do you identify with? _____

Marital Status: Married / Single / Divorced / Separated / Widowed / Other

Employment Status: Student / Employed / Retired / Other_____

Name of Employer/School_____

If client is a minor, name(s) of parents or legal guardian: _____

Address: _____

City/State/Zip:_____

Home#: (_____)_____ May I leave a message? Y / N

Cell#: (_____)_____ Message? Y / N

Email: _____ Contact by email? Y / N

In case of emergency please contact:

_____

Name Contact # Relationship to client

Why are you seeking counseling?

_____

_____

_____

_____

What are the goals you have for therapy?

_____

_____

_____

_____

History of Therapy/Mental Health

Have you ever been hospitalized for a mental health disorder? Y / N

If yes, when? _____

Are you currently receiving medical or psychiatric treatment from a physician? Y / N

Physician or psychiatrist:

_____

Name Contact #

Please list any prescribed medications:

_____

Have you ever seen a therapist in the past? Yes No When?_____

If yes, was there anything you liked about therapy?

_____

Anything you disliked about therapy?

_____

Are you currently experiencing any thoughts and/or plans for suicide? Yes No

Have you ever had a suicide attempt? Yes No If yes, when was last attempt?

_____

Do you have any history of or current self-harming behavior? If yes, when did you last self harm?

_____

_____

History with any physical, sexual, or emotional abuse/neglect? If so, what, when, by whom, and how did you cope?_____

_____

General Medical Conditions

Are there any medical problems you are currently experiencing? If yes, please list:

_____

_____

Do you currently use any mood altering substances to help cope? Ex: alcohol, marijuana, other drugs, vaping?

If so, what are you using and how frequently? _____

Psychosocial and Environmental Problems

Please check all that apply:

- Couple / Family Problems
- Legal Problems
- Economic Problems
- Educational / Academic problems
- Spiritual Issues
- Recent transition or change
- Problems with social environment
- Occupational problems
- Domestic abuse / Violence / Bullying

Symptom Checklist

- Abusing Drugs / Alcohol
- Abdominal pain / discomfort
- Agitation
- Anger / Over-reaction
- Anhedonia (loss of pleasure)
- Anxiety
- Appetite loss
- Appetite gain
- Chills or hot flashes
- Circular thinking
- Compulsive behavior(s)
- Concentration problems
- Conduct problems
- Confusion
- Craving Drugs / Alcohol
- Delusions
- Difficulty Sleeping
- Insomnia
- Hypersomnia
- Difficulty breathing
- Dizziness / Falls
- Eating problems
- Elimination problems
- Emotional numbness
- Fatigue
- Fearful / Distrustful
- Fear of dying
- Fear of losing control
- Feeling guilt-ridden
- Feeling helpless
- Feeling hopeless
- Hallucinations
- Hands trembling / shaky
- Heart pounding or racing
- Hyperactivity
- Impulsivity
- Intrusive thoughts/memories
- Loss of interest in sex
- Low energy
- Low self esteem
- Low stress tolerance
- Memory problems
- Mood swings
- Nervous
- Numbness or tingling
- Obsessions
- Oppositional/Defiant behavior
- Pessimism
- Physical pain (1-10) _____
- Poor concentration
- Pressured speech
- Racing thoughts
- Sadness
- Self-criticism
- Self-harm/mutilation
- Sexual problems
- Social anxiety
- Sweating (not due to heat)
- Tearfulness
- Terrified
- Thoughts of harming self
- Thoughts of harming others
- Unable to relax
- Vivid dreams / nightmares
- Withdrawing from people
- Worthlessness
- (Other)_____
- (Other)_____

Other Information

Is there any other information you'd like to share with your therapist?

_____

_____

_____

Client History Reviewed by therapist

Therapist Signature _____ Date _____