ellie FAMILY SERVICES
www.elliefamilyservices.com
phone: 651.313.8080 fax: 651.925.0610

Client's legal name: _____ Date: _____

Preferred name: _____

Gender: ☐ F ☐ M ☐ Other Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

Emergency contact name: _____ Phone: _____

If you need more space for any of the following questions, please use the back of this sheet.

Primary reason(s) for seeking services:

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression
☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns
☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/Drugs ☐ Gender related
☐ Other mental health concerns (specify): _____
_____
_____

Counseling/Prior Treatment History

Information about **client** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (ex. AA, Al-Anon, NA, Overeaters Anonymous)					

Information about **family/significant others** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (ex. AA, Al-Anon, NA, Overeaters Anonymous)					

Please check behaviors & symptoms that occur to you more often than you would like them to take place:

- ☐ Aggression
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Chest pain
- ☐ Cyber addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Disorganized thoughts
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating disorder
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory impairment
- ☐ Mood shifts
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Recurring thoughts
- ☐ Sexual addiction
- ☐ Sexual difficulties
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Speech problems
- ☐ Suicidal thoughts
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively:

Any additional information that would assist us in understanding your concerns or problems:

What are your goals for therapy?

Do you feel suicidal at this time? ☐ Yes ☐ No
If Yes, explain: _____

Chemical Use History

	Method of use & amount	Frequency of use	Age of first use	Age of last use	Used in last: 48 hrs (Y/N)	Used in last: 30 days (Y/N)
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

When and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:
☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication
☐ Socialization ☐ Taste ☐ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does someone in your family have a problem with drugs or alcohol (past or present)? _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ☐ Yes ☐ No
If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Does your body temperature change when you drink? ☐ Yes ☐ No
If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ☐ Yes ☐ No
If Yes, describe: _____

Family Information				
Relationship	Name	Age	Living (Y/N)	Living with you (Y/N)
Mother				
Father				
Spouse				
Children				
Other Parent/caretaker				

Significant others (ex. Brothers, sisters, grandparents, step-relatives). Please specify relationship.

Relationship	Name	Age	Living (Y/N)	Living with you (Y/N)

Marital status and length of time (more than one answer may apply):

☐ Single _____ ☐ Separated _____
☐ Legally married _____ ☐ Annulment _____
☐ Widowed _____ ☐ Divorced _____
☐ Polyamorous _____ ☐ Unmarried, living together _____
☐ Divorce in process _____ Total number of marriages: _____

Assessment of current relationship (if applicable): ☐ Good ☐ Fair ☐ Poor

Parental information:

☐ Parents legally married
☐ Parents have ever been separated
☐ Parents ever divorced
☐ Mother remarried: number of times: _____
☐ Father remarried: number of times: _____

Special circumstances (ex. Raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No
If Yes, please describe: _____

Has there been history of child abuse? ☐ Yes ☐ No
If Yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal
If Yes, the abuse was as a: ☐ Victim ☐ Perpetrator

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Other (specify): _____
Comments regarding childhood development: _____

Social Relationships

How do you generally get along with other people (check all that apply)?

☐ Affectionate	☐ Aggressive	☐ Avoidant	☐ Follower	☐ Fight/argue often
☐ Friendly	☐ Leader	☐ Outgoing	☐ Submissive	☐ Shy/withdrawn

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ☐ Yes ☐ No
If Yes, describe: _____

Any current or history of being a sexual perpetrator? ☐ Yes ☐ No
If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No
If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ☐ Not ☐ Somewhat ☐ Moderately ☐ Very

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No
If Yes, describe: _____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No
If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into counseling? ☐ Yes ☐ No
If Yes, describe: _____

Legal

Current Status:

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No
If Yes, please describe and indicate the court hearing/trial dates and charges: _____
_____
Are you presently on probation or parole? ☐ Yes ☐ No
If Yes, please describe: _____

Past History:

Traffic violations: ☐ Yes ☐ No DWI, DUI, etc.: ☐ Yes ☐ No
Criminal involvement: ☐ Yes ☐ No Civil involvement: ☐ Yes ☐ No

If you responded Yes to any of the above, please fill in the following information:

Charges	Date	Where (city)	Results

Education

Years of education: _____ Currently enrolled in school? ☐ Yes ☐ No

Fill in all that apply:
☐ High school grad/GED
☐ Vocational Number of years: _____ Graduated? ☐ Yes ☐ No Major: _____
☐ College Number of years: _____ Graduated? ☐ Yes ☐ No Major: _____
☐ Graduate Number of years: _____ Graduated? ☐ Yes ☐ No Major: _____
Other training: _____
Special circumstances (ex. Learning disabilities, gifted): _____

Employment

List job history (begin with most recent job):

Employer	Dates	Title	Reason left	How often miss work?

Currently: ☐ Full-Time ☐ Part-Time ☐ Temp ☐ Laid-Off ☐ Disabled ☐ Retired
☐ Social Security ☐ Student ☐ Other (describe): _____

Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge date: _____

Leisure/Recreational

Describe special areas of interest or hobbies (ex. Art, reading, crafts, physical fitness, sports, outdoor activities, church activities, walking, diet/health, hunting, fishing, bowling, traveling, etc.):

Activity	How often now?	How often in the past?

Medical/Physical Health

- ☐ AIDS
- ☐ Alcoholism
- ☐ Abdominal pain
- ☐ Abortion
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bed wetting
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Colds/cough
- ☐ Constipation
- ☐ Chicken Pox
- ☐ Dental problems
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Ear infections
- ☐ Eating problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headaches
- ☐ Hearing problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Menstrual pain
- ☐ Miscarriages
- ☐ Neurological disorders
- ☐ Nausea
- ☐ Nose bleeds
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Sexually transmitted diseases
- ☐ Sleeping disorders
- ☐ Sore throat
- ☐ Scarlet fever
- ☐ Sinusitis
- ☐ Smallpox
- ☐ Stroke
- ☐ Sexual problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Toothache
- ☐ Thyroid problems
- ☐ Vision problems
- ☐ Vomiting
- ☐ Whooping cough
- ☐ Other (describe):

List any health concerns: _____

List any recent health or physical changes: _____
_____

Current prescribed medication	Dose	Dates	Purpose	Side Effects

Current over-the-counter medication	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? ☐ Yes ☐ No
If Yes, describe: _____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____
_____

Please check if there have been any recent changes in the following:
☐ Sleep patterns ☐ Eating patterns ☐ Behavior ☐ Energy level
☐ Physical activity level ☐ General disposition ☐ Weight ☐ Nervousness/tension

Describe changes in areas in which you marked above: _____
_____

Nutrition

			Typical amount eaten			
Meal	How often	Typical foods eaten	No	Low	Med	High
Breakfast	/week					
Lunch	/week					
Dinner	/week					
Snack	/week					

For Staff Use

Therapist's signature/credentials: _____ Date: _____