CLIENT INFORMATION & HISTORY

Intuitus Group Counseling Clinic, PLLC
1464 E. Whitestone Blvd. Ste. 2001 - Cedar Park, TX 78613 - www.intuitus-group.com

All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Client Name _____

Address _____ City_____ Zip Code _____

Best phone number and time to reach you: _____May I leave a message? _____

Age _____ Birthdate ____/____/_____ Education Completed: _____

Name(s) & age(s) of child(ren)_____

Emergency contact: _____Relationship _____ Phone # _____

Who referred you to me? _____ May I thank this person for the referral? Y / N

Employer/Occupation _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Choose to stay at home ☐ Unemployed

Are you happy at your current position? _____

Please list any work-related stressors: _____

What concerns lead you to therapy at this time?_____

_____

_____

What goals do you have for therapy? _____

_____

_____

Are you currently receiving psychiatric care or psychotherapy elsewhere? ☐ Yes ☐ No

If Yes, with whom? _____

Please describe any previous therapy experience: _____

_____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? ☐ Yes ☐ No

If Yes, please list: _____

Please list medications taken in the past: _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, describe: _____

Have you thought about or attempted suicide? ☐ Yes ☐ No

If yes, please describe: _____

HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns: _____

_____

Current medications: _____

Primary care physician: _____ Phone # _____

Are you having any problems with sleep? _____ _____

What are your exercise habits? _____

Are you having any difficulty with appetite, weight or eating habits? ☐ Yes No

If yes, describe: _____

Do you smoke or use tobacco? ☐ Yes ☐ No Please describe: _____

Do you drink alcohol? ☐ Yes ☐ No Please describe: _____

Do you use other/recreational drugs? ☐ Daily ☐ Often ☐ Rarely ☐ Never ☐ Not any more

If at all, please describe: _____

Have you ever experienced a concussion or other head injury? If yes, list date(s) and information known:

_____

_____

Current relationship status: Single | Dating | Separated | Living together | Married | Divorced | Widowed

If applicable, please describe the quality of your current relationship: _____

_____

Please describe your relationship history: _____

_____

What of the following have you experienced or noticed in yourself in the **past year**? (check all that apply)

Chronic Pain or Illness
Educational Problems
Family or Parenting Conflict
Financial Problems
Grief/Loss
Legal Problems
Loneliness
Major Life Change
Other (specify): _____

Concentration or Memory Difficulty
Compulsive or Impulsive Behaviors
Restlessness
Sexual Dysfunction
Social Discomfort/Shyness
Identity Confusion
Spiritual Confusion
Trauma or disturbing life experience

FAMILY & MENTAL HEALTH HISTORY:

Check if yes	Who?	Received treatment?
__ Depression		Y / N
__ Bipolar Disorder		Y / N
☿☿ Anxiety Disorders		Y / N
__ Panic Attacks		Y / N
☿☿ Schizophrenia		Y / N
☿☿ Addiction		Y / N
☿☿ Eating Disorders		Y / N
☿☿ Learning Disabilities		Y / N
☿☿ ADHD		Y / N
__ Trauma/Abuse History		Y / N
☿☿ Suicide Attempts		Y / N

Briefly describe your relationship with your:

Mother: _____
Father: _____
Sibling(s): _____
Extended family: _____
Child(ren): _____

Do you consider yourself to be religious? _____ If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? _____

Do you feel that your faith should be a significant part of your therapy? ☐Yes ☐ No

Please describe: _____

What do you consider to be your strengths?_____

_____

What do you like most about yourself?_____

_____

How do you typically cope with problems in your life? _____

_____

Adverse Childhood Experiences Scale

These questions are based on the Adverse Childhood Experiences Study, originally by Kaiser Permanente in 1997.
See www.acestudy.org for more information.

Please circle "yes" or "no" for each question below.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**... Swear at you, insult you, put you down, or humiliate you?
Or - Act in a way that made you afraid that you might be physically hurt?
Yes / No

2. Did a parent or other adult in the household **often or very often**...
Push, grab, slap, or throw something at you? **Or - Ever** hit you so hard that you had marks or were injured?
Yes / No

3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way?
Or - Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes / No

4. Did you **often or very often** feel that ...No one in your family loved you or thought you were important or special?
Or - Your family didn't look out for each other, feel close to each other, or support each other?
Yes / No

5. Did you **often or very often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
Or - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes / No

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
Yes / No

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
Or - Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
Or - Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes / No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes / No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes / No

10. Did a household member go to prison?
Yes / No

Is there anything else you want me to know? _____

_____

_____

Client Signature _____ Date _____