Blue Stone Counseling LLC
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Client Information (Please Print Clearly)

LAST NAME **FIRST** **MI** **BIRTHDATE** **AGE**

ADDRESS **SSN** **GENDER**

CITY **STATE** **ZIP CODE**

PRIMARY PHONE # **SECONDARY PHONE #**

EMERGENCY CONTACT PERSON **RELATIONSHIP** **PHONE**

SPOUSE OR PARENT(S) NAMES **PHONE**

PSYCHOLOGICAL HISTORY:

1. **PRESENTING CONCERN/WHAT BRINGS YOU INTO COUNSELING?**

2. **WHEN DID THIS CONCERN FIRST BECOME NOTICEABLE?**

3. **DOES IT INTERFERE WITH WORK, SOCIAL FUNCTION OR YOUR EDUCATION?**

4. **WHAT ARE THE DEFINING SYMPTOMS? (ALSO SEE SYMPTOM CHECKLIST ON NEXT PAGE)**

5. **WHO MADE THE DECISION TO COME TO THERAPY?**

6. **HAVE YOU EXPERIENCED ANY RECENT ILLNESSES OR DEATHS AMONG FAMILY OR CLOSE FRIENDS?**

7. **HAVE YOU EXPERIENCED ANY RECENT CRISES OR MAJOR CHANGES IN YOUR LIFE?**

9. **HAVE YOU EXPERIENCED ANY EMOTIONAL, PHYSICAL OR SEXUAL TRAUMA?**

MEDICAL HISTORY:

1. **LIST ANY CURRENT MEDICAL CONDITIONS OR DISABILITIES:**

2. **ARE YOU TAKING ANY MEDICATIONS? _____ IF YES, PLEASE LIST PRESENT AND RECENT PAST MEDICATIONS BELOW.**

FREQUENCY ABBREVIATIONS: qd=each day, bid=2X/day, tid=3X/day, qid=4X/day, qhs=each evening, qam=each morning, prn=as needed

MEDICATION	DOSE	FREQUENCY	PRESCRIBER	START/END DATES

3. **NAME/CONTACT INFORMATION OF PRIMARY CARE DOCTOR:**

4. **DATE OF LAST MEDICAL EXAM: _____**

5. **ANY OTHER SIGNIFICANT HEALTH HISTORY?**

Blue Stone Counseling L.L.C. Patient Name:_____

SYMPTOM CHECKLIST

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero to four that best describes how much this symptom or feeling bothers you. Use the following scale:

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

In the <u>past week</u>, how much were you bothered by:

		Not at All		Moderately		Extremely
1.	Feeling depressed, sad, blue, down, unhappy most of the time	0	1	2	3	4
2.	Feeling easily annoyed or irritated	0	1	2	3	4
3.	Feeling no interest in things or avoiding enjoyable activities, family, or friends	0	1	2	3	4
4.	Feeling tired all the time even with adequate sleep	0	1	2	3	4
5.	Trouble concentrating; can't stay focused on activities	0	1	2	3	4
6.	Feeling lonely even when you are with people	0	1	2	3	4
7.	Feeling hopeless about the future	0	1	2	3	4
8.	Significant increase or decrease in appetite or weight	0	1	2	3	4
9.	Sleeping problems: can't fall asleep, restless sleep, sleeping too much	0	1	2	3	4
10.	Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2	3	4
11.	Suicide attempt: Intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2	3	4
12.	Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money	0	1	2	3	4
13.	Doing things without thinking and often getting yourself into a jam	0	1	2	3	4
14.	Feeling so restless you could not sit still	0	1	2	3	4
15.	Feeling anxious: worrying excessively or worry about many things	0	1	2	3	4
16.	Feeling tense or keyed up	0	1	2	3	4
17.	Spells of terror or panic	0	1	2	3	4
18.	Fearful feelings of being humiliated in social situations	0	1	2	3	4
19.	Feeling uneasy in crowds or in open spaces	0	1	2	3	4
20.	Feeling afraid to travel on buses, subways, trains, or planes	0	1	2	3	4
21.	Feeling inferior to others	0	1	2	3	4
22.	Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
23.	Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling "nothing" or numb, as if blocked as in taking a pain killer	0	1	2	3	4
26.	Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2	3	4
27.	Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc)	0	1	2	3	4
28.	Feeling that you are watched or talked about by others	0	1	2	3	4
29.	Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3	4
30.	The idea that someone else can control your thoughts	0	1	2	3	4
31.	Feeling that most people cannot be trusted	0	1	2	3	4
32.	Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	4
33.	Episodes of binge eating, purging/vomiting, or periods of not eating	0	1	2	3	4
34.	Feeling others are to blame for most of your troubles	0	1	2	3	4
35.	Having urges to break or smash things or injure someone	0	1	2	3	4
36.	Other:	0	1	2	3	4

BLUE STONE COUNSELING L.L.C. Patient Name:_____

DRUG AND ALCOHOL USE

A. Please describe the drug and alcohol use of your family. Use the number which best describes how often each person uses each drug. For your children, please write in the name of child at top of each column.

0 = never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBTANCE	SELF	PARTNER/SPOUSE	CHILD	CHILD	YOUR PARENTS
Caffeine					
Nicotine					
Beer/wine/liquor					
LSD					
Marijuana					
Inhalants					
Sedatives					
Amphetamines					
Cocaine/Crack					
Other (specify)					

B. Are you concerned about your drug or alcohol use? ☐ Yes ☐ No

C. Is someone who cares about you concerned about your use of drugs or alcohol? ☐ Yes ☐ No

D. Do you ever feel guilty about your use of drugs or alcohol? ☐ Yes ☐ No

E. Are you concerned about the alcohol or drug use of someone in your family? ☐ Yes ☐ No

F. Did you grow up in a home in which a parent abused drugs or alcohol? ☐ Yes ☐ No

G. Has anyone in your family been in treatment for drug or alcohol abuse? ☐ Yes ☐ No

List who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

A. Do you have serious financial concerns? ☐ Yes ☐ No

B. Have you ever been arrested? ☐ Yes ☐ No

C. Have you ever been involved with Protective Services? ☐ Yes ☐ No

SCHOOL, MILITARY & WORK HISTORY

A. Are you currently enrolled in school? ☐ Yes ☐ No

B. What is your highest grade completed? _____

C. If you are in school, what field are you studying? _____

D. Have you served in the military? ☐ Yes ☐ No

If yes, which branch? _____ When? _____

E. Are you currently employed? ☐ Yes ☐ No

If yes, what is your occupation? _____

What is the length of time at your current job? _____

_____ _____

CLIENT SIGNATURE DATE

_____ _____

CLIENT PARENT OR GUARDIAN (IF MINOR) DATE