The Mental Health Counseling Group, PLLC
Crossbridge Counseling

Today's Date _____

Client Name: _____ Date of Birth _____

Address:

_____

Street City Zipcode

Telephone
(Home):_____(Cell):_____

Your Employer: Work Phone #(if appropriate)
_____
_____

Full time_____ Part time _____ How Long?
_____

Prior Job History
_____

Are you a student? Full time_____ Part-Time_____
Where?_____

Highest Level of Education
Completed: _____

Current Spouse or Partner's Name	Age	Sex	**Previous Marriages or long term relationships; give beginning & end dates**		
Together since					
Children at home – Names	Age	Sex	**Children NOT currently with you – Names**	Age	Sex
1st					
2nd					

3rd

MEDICAL HISTORY

Name of Primary Care Physician: _____ Phone #: _____

Address:

_____

Current Medications:
Name_____ for _____
dosage_____

Name _____for _____
dosage_____

Name _____for _____ dosage _____

Over the counter meds, including vitamins, herbs, & supplements

_____

_____

_____

Date of last physical exam _____

Any physical problems at this time? Describe concerns.

_____

Do you have any problems with pain?

_____

Your estimation of your overall health:

____Excellent ____Good ____Fair ____Poor ____Very Poor

Do you eat regular meals? _____ Do you have any appetite problems?
_____

Have you ever struggled with an eating disorder or problem?
_____

Do you exercise, if yes what type and frequency?
_____

Serious illnesses and
hospitalizations:_____

Did you ever have a head injury or were you ever in a coma?
_____

Any current serious illnesses or hospitalizations in other family members?

_____

Do you have any sexual concerns?

_____

Religious Affiliation if any Membership? Where?

_____
_____

Religious/ Spiritual Preference if any

_____
__

Were you raise in a specific faith tradition? Y/N
If yes, was it positive, negative or neutral experience_____

Role of Spirituality in your life
_____
_

Religious/Spiritual doubts or confusion
_____

Ethinc/cultural Background:

_____
_

Any ethnic problems/concerns?

_____

MENTAL HEALTH HISTORY

Have you ever experienced any of the following?

Concern about your own use of alcohol or other drugs? YES NO

Concern about the use of alcohol or drugs by someone close to you YES NO

Had an unwanted sexual experience? YES NO

Experienced a violent or otherwise traumatic experience? YES NO

Have any family members hospitalized for mental health issues? YES NO

Have any losses in your life that were significant to you? YES NO

A psychotic episode? YES NO

Experienced domestic violence? YES NO

Have you had previous psychotherapy? YES NO Date_____

Name (s) of previous therapist(s):_____

Reason treatment sought:

_____

Reason(s) for termination:

_____

Have you ever gone to the ER for mental health concerns? YES NO

Have you ever been admitted for inpatient mental health treatment? YES NO

If yes, the year(s)

_____

Facility

_____

Have/had a family member who suffered from the following problems?

Anxiety/panic/nervousness YES NO Alcohol or drug abuse YES NO
Depression YES NO Schizophrenia YES NO
Bipolar Disorder YES NO Other Mental Illness YES NO
Learning disability YES NO ADHD YES NO
Domestic Violence YES NO Suicide or attempts YES NO
Eating Disorders YES NO OTHER

Any suicidal ideation, plans, or thoughts of harming yourself_____

Any plan or intent to harm self or others? _____

Weapons in home available? _____

Any previous attempts to harm self or others?

_____

Have you ever hit, pushed, slapped or choked anyone? _____

During arguments/fights do you threaten, throw or break things, punch the walls or slam doors, yell or scream at your partner, children or others?

_____

SUBSTANCE USE

*If you answer yes to any of the questions below please include type of drug**, amount and frequency of use***

Do you drink alcohol more than once a week?_____

How often do you engage recreational drug use?

_____

Do you use nicotine?

_____

What about caffeine intake?

_____

At what age did you first try drugs or alcohol?

_____

Have you ever received inpatient or outpatient drug or alcohol treatment? If yes please give dates and facility names.

_____

_____
__

Questions: yes or no

1. Have you ever felt that you ought to cut down on your drinking or drug use?

2. Have people annoyed you by criticizing your drinking or drug use?

3. Have you ever felt bad or guilty about your drinking or drug use?

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover

Check each drug that you have used in the past or are currently using. Indicate date of last use.

Alcohol

Marijuana

Heroin

Methamphetamine

Benzodiazepines

Inhalants

Cocaine

Ecstacy

Inhalants

_____

Other

_____

FAMILY OF ORIGIN INFORMATION

Client's Family of Origin

Name (Father, Mother, Siblings)	Age	sex	Describe your current relationship, ex, warm, close, distant, hostile	If deceased date and cause

Spouse or Partner Family of Origin

Name (Father, Mother, Siblings)	Age	Sex	Describe your spouse/partner's current relationship, see examples above	Deceased (date and cause)

Is there anything else you feel I should know, or you wish to share, before working together?

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONAIRRE