John W. Steele, Ph.D., Licensed Psychologist
Patient/Client History and Background Form

Your honesty aids my work in terms of integrating themes and current life functioning. Thank you for your time in filling out this form.

Client/Patient's full name: _____
Date: _____

Client's Social Security #_____ Age ____ Gender __F __M

Address_____ City _____
State _____Zip_____ home phone _____
work_____ cell_____

Birthdate ___/____/_____ Race/Ethnicity_____

Name of Spouse/Guardian_____ Phone _____

**Emergency Information**
In case of emergency, please contact:
Name_____
Relationship_____
Phone_____
Address_____

**Employment Information**
Client: Place_____
Occupation_____ Hrs_____ EAP? ___ yes ____no

Spouse: Place_____
Occupation _____ Hrs _____ EAP? ___yes ____no

**Insurance Information**
Primary Insurance_____
Contract/ID#_____
Group/Acct#_____
Subscriber_____
Subscriber DOB_____
Subscriber SS#_____

Secondary Insurance _____
Contract/ID#_____
Group/Acct #_____

Subscriber _____
Subscriber DOB_____
Subscriber SS#_____
Client's relationship to Subscriber? ____Self ____Spouse ____Son/Daughter

**Referral Source**
How did you hear about my services? _____
Address_____ City_____
State_____ Zip_____ Phone_____ May I thank them?_____
Do you (client) have a: ___conservator ___guardian ___representative payee
____No ____Yes Name_____
Phone_____
Address_____
Primary Reason for seeking services:
___Anger Management
___Anxiety
___Fears or Phobias
___Coping
___Mental Confusion
___Alcohol/Drugs
___Depression
___Sexual Concerns
___Eating Disorder
___Sleeping problems
___Other mental health or behavioral concerns
How long have you been experiencing these problems? _____

For those areas that apply to you, rate how much distress you feel related to this issue on a regular basis, with 0 being no distress and 10 being extreme distress.

| | | |
|---|---|---|
| ___Aggression | ___Elevated Mood | ___Phobias/fears |
| ___Alcohol dependence | ___Fatigue | ___Recurring thoughts |
| ___Anger | ___Gambling | ___Sexual Addiction |
| ___Antisocial behavior | ___Hallucinations | ___Sexual Difficulties |
| ___Anxiety | ___Heart palpitations | ___Sick Often |
| ___Avoiding people | ___High Blood Pressure | ___Sleeping problems |
| ___Chest Pain | ___Hopelessness | ___Speech problems |
| ___Computer Addiction | ___Impulsivity | ___Suicidal Thoughts |
| ___Depression | ___Irritability | ___Thoughts disorganized |
| ___Disorientation | ___Judgment errors | ___Trembling |
| ___Distractibility | ___Loneliness | ___Withdrawing |
| ___Dizziness | ___Memory Impairment | ___Worrying |
| ___Drug Dependence | ___Mood Shifts | ___Other (specify_____) |
| ___Eating Disorder | ___Panic Attacks | |

What areas of your life are affected by the above?

Social
___Unable to form or maintain friendships
___Withdrawal from family and friends
___Increased conflict with others
___Loss of interest in social activities
___Phobias

Occupational
___Unable to maintain job
___Absenteeism
___Conflicts with co-workers
___Tardiness
___Reduced Productivity
___Disciplinary Action for Poor Performance

Academic
___failing grades
___truancy
___tardiness
___detention
___reduced productivity at school
___fighting/conflicts with students/teachers

Affective Distress
___crying spells
___mood swings
___anger/rage
___disorganized thoughts
___feeling overwhelmed with emotions
___worrying that interferes with the ability to concentrate
___memory problems
___concentration problems

Physical
___decreased energy/fatigue
___difficulty getting out of bed or insomnia
___decreased/increased appetite
___substantial weight loss or gain
___physical complaints (headaches, stomachaches)
___frequent illness

**Family Information**
Your current relationship status:
___single ___divorce in process ____unmarried, living together
___legally married ___separated ____divorced
___widowed ___annulment

Relationship with significant other: ___good ___fair ___poor ___N/A

| Relationship | Name | Age | Living? Yes | Living? No | Living with you? Yes | Living with you? No |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |
| Spouse | | | | | | |
| Children | | | | | | |
| | | | | | | |
| | | | | | | |
| Others | | | | | | |
| | | | | | | |

**Development**
Are there special, unusual, or traumatic circumstances that affected your development? __yes ___no
If yes, please describe
_____
Has there been any history of child abuse _____yes _____no
If yes, which type(s)? _____sexual ____physical _____ verbal
Other issues ____neglect ___inadequate nutrition ___poor health
___ other (please specify) _____

**Social Relationships**
Check how you generally get along with other people (check all that apply):
___Affectionate ___Aggressive ___Avoidant ___Fight/Argue Often
___Follower ___Friendly ___Leader ___Outgoing ___Shy/Withdrawn
___Submissive
___Other (specify)_____

Do you currently have supportive friendships? ___yes ___no

Sexual Orientation_____
Sexual Dysfunctions? ___yes ___no

**Cultural/Ethnic**
To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural/ethnic issues? ___yes ___no
If yes, please describe_____
**Spiritual/Religious**
How important to you are spiritual matters? ___ Not at all ___ a little
___ moderately ___ very
Are you affiliated to a spiritual/religious group? ___yes ___no
Which one? _____
Would you like your spiritual/religious beliefs incorporated into the counseling?
___ yes ___no

**Current and Past Legal Status**
Are you involved in any active cases (civil or criminal)? ___ yes ___no
If yes, please describe and indicate the court and hearing/trial dates and charges_____

Are you presently on probation or parole? ___ yes ___no
Please list any previous criminal or civil charges
_____

**Education**
Check all that apply
High School graduate? ___ yes ___no
College graduate? ___ yes ___no Major_____
Are you currently enrolled in school? ____yes ___no
Other Training?
_____

**Employment**
Current Employer _____Dates_____
Title_____ ____FT ___PT ___TEMP ___laid-off
___disabled ___retired ___ social security ___student
Any military experience? ___ yes ___no
If yes, which branch, type of discharge and rank at discharge _____

**Leisure/Recreational**
Describe special areas of interest or hobbies (art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)
Activities_____
How often now?_____
How often in the past?_____

**Personal History of:**

| | Currently | In the Past | Never |
|---|---|---|---|
| Alcohol Abuse | | | |
| Depression | | | |
| Bipolar | | | |
| Suicide Attempt | | | |
| Nervousness | | | |
| Psychiatric Hospitalization | | | |

**Family History of:**

| | Currently | In the Past | Never |
|---|---|---|---|
| Alcohol Abuse | | | |
| Depression/Anxiety | | | |
| Drug Abuse | | | |
| Bipolar | | | |
| Suicide Attempt | | | |
| Psychiatric Hospitalization | | | |

**Current and Past Health Concerns**

Please list any current health concerns _____

Past health concerns

_____

_____

_____

_____

Name of Primary Physician_____

Phone_____

Date of last physical exam_____

Previous or upcoming surgeries? _____

Do you have any disabilities? ___no ___yes If yes, describe and note how it affects your physical and/or psychological functioning and how you adjust to your disability_____

**Current Medications**

Name of current meds, dosage, when you take and how often as well as usage_____

Please list any nutritional and herbal supplements you currently take_____

_____

How long have you been taking medication?

_____

_____

Please list medications you have taken in the past_____

How long did you take it?

_____

Why was it stopped?

_____

Medication Allergies? ___yes ___no If yes, what allergies?

_____

_____

**Nutrition**

| Meal Eaten | How often (per wk) | Typical foods eaten | Amount |
|---|---|---|---|
| Breakfast | ___/ week | _____ | ___low ___med __high |
| Lunch | ___/ week | _____ | ___low ___med __high |
| Dinner | ___/ week | _____ | ___low ___med __high |
| Snacks | ___/ week | _____ | ___low ___med ___high |

**Chemical Abuse History**

Please check which substances you have used in the past:

___alcohol ___barbiturates ___Valium/Librium ___Cocaine/Crack ___Heroin/Opiates

___marijuana ___PCP/LSD ___Inhalants ___Caffeine ___Nicotine

___Over the counter___ prescription drugs ___other _____

Are you using any of these substances currently? ___yes ___no If yes, which ones?

_____

_____

How often?_____ Use in the last 48 hours?_____ In last 30 days? ____

Explain_____

Have you ever had any withdrawal symptoms when trying to stop using drugs or alcohol? ____yes ____no Please describe _____

_____

Have drugs ever created a problem for your job? ____yes ___no If yes, please describe_____
_____

**Prior Counseling/Psychiatric Treatment**

Have you had previous treatment? ___ yes ___no If yes, please describe your experience

_____
_____

Any previous mental health diagnoses?

_____

What are your goals for therapy? How will you know when you are ready to end therapy? _____
_____

Do you feel suicidal at this time? ____ yes ____no If yes, explain

_____
_____

Are you currently involved in any risk-taking behaviors?

_____
_____

Client's signature_____
Date_____

Parent/Guardian (If applicable)_____
Date_____

Therapist's signature/credentials _____
Date_____