BREAKTHROUGH FAMILY COUNSELING

510 E BERKELEY ST. GLADSTONE, OR 97027

PERSONAL HISTORY

Today's date: _____________ Name: ____ DOB: ______________

Preferred Name: _______________________ Gender: ________________ Ethnicity: _______________________

Disabilities: ____

Phone:______________________ Address: ____

Relationship Status: Married Single Engaged Divorced Cohabiting Widowed

PRESENT LIVING SITUATION

Please fill in the following information for all of your children.

Name of your child	Age	Who he/she is living with	School he/she is attending

Please fill in the following information for anyone else who is living with you.

Name	Age	Relationship with you

PERSONALITY INFORMATION

As you see yourself, what kind of person are you? Describe yourself. _____________________________________

____

____

____

If I were to ask other people to describe you, what five words would come up most frequently?

___________________________ ___________________________ ___________________________

___________________________ ___________________________

What are you greatest fears?

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Identify any irrational, negative, or 'horrible' thoughts that bother you: ____________________________________
____

Identify any habits, practices or behaviors that you would like to change: ____________________________________
____

State in your own words what you would consider to be the nature of your main problem(s): __________________
____
____
____

Describe when and how your problem(s) began: ____
____

I estimate the severity of my problem(s) to be (circle one):

Just an irritant	Mildly upsetting	Moderately severe
Very severe	Extremely severe	Totally incapacitating

What have you done about it? ____
____

What do you expect the counselor to do for you? ____
____
____

Have you sought other professional help with this problem (circle one): Yes No

If yes, give name(s) and professional title(s) of the therapist(s), dates of treatment(s) and results:
____
____
____

List three goals you have for self-improvement:

1. ____
2. ____
3. ____

List four major strengths or abilities:

1. ____
2. ____
3. ____
4. ____

Please check off all individual items that concern you:

Academic concerns	Fears	Relationship issues
Alcohol use	Finances	Relaxation
Anger	Friends	Self-control
Appetite	Health Problems	Shyness
Body changes	Inferiority feelings	Sleeplessness
Career choices	Legal matters	Suicidal thoughts
Depression	Loneliness	Thoughts
Dreams	Making decisions	Tiredness
Drug use	Memory	Unhappiness
Eating disorders	Nervousness	Work
Education	Pornography	Other ____________________________

PERSONAL HISTORY

Where were you born? __________________________ Where did you grow up? __________________________

How many places did you live before you finished high school? ____

How many schools did you attend through grade 12? ___

How many brothers do you have? _____ How many sisters? _____ Which number are you in birth order? ____

List your siblings: Name ___________________________ Age __________________

___________________________ __________________

___________________________ __________________

___________________________ __________________

Please mention any step or half brothers and sisters you have: ____

____

Were there any unusual circumstances regarding your conception or birth? ________________________________

____

What is/was your mother like? How did she treat you as a child? ____

____

What is/was your father like? How did he treat you as a child? ____

____

Information about your parents and their marriage: ____

____

Please describe any deaths in your family while you were growing up; include your age at the time: ____________

____

____

Did anyone in your family attempt or attempt and/or complete suicide? Y / N Who?______________________

Were your parents divorced or separated (circle one): Y / N If yes, explain:____________________________

____

How old were you and how did you react? ____

____

Why did the divorce or separation occur? ____

With which parent did you live? ______________________________

What were your favorite things to do as a child? ______________________________

____

How did you parent(s) typically discipline you? ______________________________

____

Please circle any of the following that describes your family and home atmosphere as a child:

Alcoholism	Competitive	Mental illness	Poverty	Sexual abuse
Affectionate	Democratic	Moving excessively	Prejudice	Stable
Angry	Distant	Neglectful	Physical illness	Supportive
Close	Fighting	No fun	Physical abuse	Trusting
Cold	Frightening	Overprotective	Rigid	Other:____________

SOCIAL EXPERIENCE

Are you satisfied with your current social life? Please explain: ______________________________

____

Please describe any organized or informal social groups that you are actively involved in: ____________________

____

When did you first begin dating? Were your early dating experiences positive? ______________________________

____

Describe your relationship with your best friend and how often you get together: ______________________________

____

When was the last time you were together? ______________________________

Information about your childhood, schooling and friends: ______________________________

____

EDUCATIONAL EXPERIENCE

What was the last grade in school (or degree) which you completed? ______________________________

Please note any certificates, degrees or licenses which you have earned or other informal training (include approximate dates): ______________________________

Have you ever begun a training or academic program and stopped? If so, briefly describe the circumstances:

____

____

How did you do academically in school (elementary, middle, high)? ______________________________

____

Have you ever been tested for a learning disability? ______________________________

SPIRITUAL EXPERIENCE

If any, what religious or spiritual tradition do you identify with?______________________________

Please describe your family's spiritual or religious atmosphere while you were growing up: ___________________
____
____

When did you develop your current spiritual beliefs? ____
____

Do your family and friends share your current beliefs? ______________________________________

Identify any religious/spiritual questions or problems that are of concern to you: ________________
____

Explain any recent changes in your religious life, if any: ____________________________________
____

MOOD SCALE

Please indicate your general mood level for the last month by circling one of the numbers on the scale:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
Suicidal Depressed Average Good spirits Joyful

Now mark an "L" over one of the numbers to describe the low point of your mood during the last year.

ANXIETY SCALE

Place an "X" over one of the numbers on the 1-10 scale below to indicate your general level of anxiety or nervousness over the last month. The higher the number you indicate, the higher the level of anxiety, nervousness, and tension you are reporting.

1 2 3 4 5 6 7 8 9 10
Peaceful Panicky

MENTAL HEALTH HISTORY

Have you ever been in counseling or therapy before? Yes / No

If yes, when? _______________________ What issues did you work on? ____________________________

Name of counselor/therapist: ____

Have you ever been hospitalized for an emotional/mental disturbance? Yes / No

If yes, when? _______________________ Please describe issues and the results: _____________________
____
____

What medications were given? ____

In the last month have you taken any medication for nervousness, depression, insomnia, or pain? Yes / No
If yes, what medicine? ____

Have you ever experienced suicidal thoughts? Y / N

If yes, please provide approximate date(s): ______________________________________

Have you ever attempted suicide? Y / N

If yes, please provide approximate date(s): ______________________________________

Are you suicidal now? Y / N

If yes, do you have a plan? **0 ---10**

No plan Immediate plan

MEDICAL HISTORY

When was your last physical examination? ______________________________

Name of your physician: ______________________________

Please list any surgeries you have had, including dates: ______________________________

____

Please tell of any accidents or injuries you have had, including dates: ______________________________

____

Please describe any head injuries, seizures or loss of consciousness you have had, including dates: _____________

____

Are you taking any medication for physical symptoms now? __________

If yes, what medication are you taking? ______________________________

____

Please check any of the following that apply to you:

Back pain	Blackouts	Burning/itchy skin	Chest pains
Constipation	Diarrhea	Dizziness	Don't like being touched
Dry mouth	Fainting spells	Fatigue	Excessive sweating
Flushes	Headaches	Hearing problems	Indigestion
Nausea	Numbness	Overeating	Muscle spasms
Palpitations	Seizures	Poor appetite	Rapid heart beat
Tension	Tics	Skin problems	Sleeping too much
Tingling	Tremors	Sleeplessness	Stomach trouble
Twitches	Vomiting	Unable to relax	Visual disturbances
Watery eyes	Weight gain	Weight loss	Other ____________

Please circle if you feel:

Overweight Underweight Concerned about eating habits

CHEMICAL SUBSTANCE USE

Family use: Does/did anyone in your family of origin, or in your immediate family, use alcohol or drugs (either prescription or street drugs)? Yes / No

Personal use: What alcoholic beverages did/do you use? ______________________________

How much? ____________________ How often? ____________________

When did you have your last drink? ______________________________

What non-prescription drugs did/do you use? ______________ When did you last use? ______________

Do you use nicotine? _____ How much daily? _________ Caffeine? ____ How much daily? ______________

OTHER THOUGHTS

Please add or emphasize any other information that you would like your counselor to know so that he/she may better understand you: ____

____

____

Do you understand that your counselor ***will not*** be available outside of regular office hours for crisis intervention or emergencies? Yes No

If you have an emergency please call 911 or the Multnomah County Crisis Line at 503-988-4888.

Do you understand that if you do not cancel an appointment more than 24 hours in advance that you will be changed for the session? Yes No

I have done my best to answer these questions as honestly and completely as possible.

________________________________ ________________

Client Signature Date