Eddie P. Millhollon, Ph.D., LPC-S
Caledonia Family Counseling LLC

Adult Client Information

Today's Date ______________________

Name ______________________ DOB ____________ Age ______

Address ______________________ ______________________ ______ ______
street city state zip

Phone (cell) ______________ (work/home) ______________ Best time to call ________

Email address ______________________ Social Security Number ______________

May I have permission to contact you and leave a message through

☐ Cell VM ☐ Cell Text ☐ Home/Work VM ☐ Email

Marital Status

☐ Single
☐ Engaged
☐ Married (how long) __________ Number of times married __________
☐ Separated (how long) __________
☐ Divorced (how long) __________

Education ______________ Occupation ______________________

Spouse's Name ______________________ DOB ______________ Age ________

Spouse's Education ______________ Spouse's Occupation ______________________

List those in your family: name, birth date, sex and relationship to you (biological, step-children, foster or adoptive children, etc.). Indicate if they are living in your home.

First and last name	Birth Date	Sex	Relationship	At Home?

Please state why you are seeking counseling. ______________________

____

____

What is the intensity of this problem and the impact on your quality of life? ______________

____

____

____

Have you struggled with this issue before? If so, when? How did you handle it before? ____________________

____

____

____

Describe the first time you felt this way. What were you doing? ____________________

____

____

____

What does a typical day look like for you? ____________________

____

____

What is your most difficult relationship right now? ____________________

____

What is your most difficult emotion right now? ____________________

____

Have you had prior counseling? ☐ Yes ☐ No

If yes, when? __________ Where? __________ With whom? __________
For what purpose? ____________________

____

Please tell me about your previous counseling experience. ____________________

____

____

Are you or another family member currently seeing a psychiatrist or another counselor? ☐ Yes ☐ No
If so, which family member? __________ Name of psychiatrist or counselor __________
For what purpose? ____________________

CRISIS INFORMATION
Do you have any current suicidal thoughts, feelings, or actions? ☐ Yes ☐ No
If yes, explain. ____________________

____

On a scale of 1 to 10, with 1 being minimal and 10 being severe, how intense are these feelings? __________
Have you acted on any part of these thoughts? _____ If so, tell me about that. ____________________

____

____

Have you had any suicidal acts or attempts? ☐ Yes ☐ No If yes, how many attempts? ______________

Describe the method used ____

____

Did anyone know of the attempts? ____

Do you have homicidal or assaultive thoughts or feelings, or anger-control problems? ☐ Yes ☐ No

If yes, explain. ____

____

Have you had any past problems, hospitalizations, or arrests for suicidal or assaultive behavior? ☐ Yes ☐ No

If yes, explain. ____

____

Have you had any recent significant losses or harm (family relationships, illness, divorce, job loss, etc)? ☐ Yes ☐ No

If yes, explain. ____

____

Are there any current threats of financial hardship or legal issues? ☐ Yes ☐ No

If yes, explain. ____

____

Would you or others describe you as impulsive? ☐ Yes ☐ No

If yes, explain. ____

____

Would you consider yourself a "burden" to others? ☐ Yes ☐ No

If yes, explain. ____

____

Do you or someone in your home own a firearm? ☐ Yes ☐ No

FAMILY BACKGROUND

Father's Name ______________________ Age ____ Occupation ______________________

State of Health ______________________ Resides in ______________________

If deceased, how long ago was the loss? ____

List three words that describe your father (e.g. loving, mean, controlling, etc.) ______________________

____

How do/did you get along? ____

Mother's Name ______________________________Age ____ Occupation ______________________________
State of Health ____Resides in ______________________________
If deceased, how long ago was the loss? ____
List three words that describe your mother (e.g. loving, mean, controlling, etc.) ______________________________
____
How do/did you get along? ____

Step-Father's Name __________________________Age ____ Occupation ______________________________
State of Health ____Resides in ______________________________
If deceased, how long ago was the loss? ____
List three words that describe your step-father (e.g. loving, mean, controlling, etc.) ______________________________
____
How do/did you get along? ____

Step-Mother's Name __________________________Age ____ Occupation ______________________________
State of Health ____Resides in ______________________________
If deceased, how long ago was the loss? ____
List three words that describe your step-mother (e.g. loving, mean, controlling, etc.) ______________________________
____
How do/did you get along? ____

Brothers and sisters. Please list them in birth order.

First and last name	Age	Resides In	Close	Distant	In Between

List family members who have/had or were suspected to have/had a mental illness.

First and last name	Relationship	Mental Illness	Officially Diagnosed?	Hospitalized?

Your happiest memories of you and your family as a child are ______________________________________
____
____

Your most unpleasant memories of you and your family as a child are ______________________________

____

____

Have you ever experienced any of the following?
___ Harsh physical punishment or abuse
___ Sexual advances made toward you as a child
___ Sexual abuse
___ Incest
___ Rape
___ Verbal or emotional abuse by a spouse or lover
If so, please explain ____

____

____

____

SUBSTANCE USE/ABUSE HISTORY
Are you presently or have you in the past used alcohol on a regular basis? ☐ Yes ☐ No
If yes, please list type of drink (e.g. beer, wine, whiskey, etc.), frequency of use, when you began use, and approximate date of last use. ____

Are you currently, or have you in the past, used any non-prescription drug(s)? ☐ Yes ☐ No
If yes, please list name of drug(s), frequency of use, when you began, and approximate date of last use. ____________

____

____

MEDICAL INFORMATION
Please list any current medical problems or symptoms you are concerned about.
1. ____
2. ____
3. ____

Please give information concerning <u>all</u> prescription or over-the-counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

Name	Dosage/How Often	Reason Taken	Taken how long	Reaction

Resiliency and Strengths: Check any areas that apply and add what is unique about you.

___ Supportive social network (friend(s), family, etc.)
___ Responsible to family and others
___ Engaged in work/career (Job satisfaction)
___ Ability to overcome difficult circumstances/events in the past
___ Hobbies/Interests:
___ Frustration tolerance
___ Ability to manage stress
___ Strong desire to live life
___ Pet(s)
___ Other: ____

Check any of the following that you experienced or identify with

___Anger
___Detachment/Numbness
___Nightmares
___Anxiety
___Panic attacks
___Phobias or severe fears
___Mood swings
___Racing thoughts
___Lack of concentration
___Memory Loss
___Fainting spells, feeling light headed or dizzy
___Loneliness
___Difficulty managing time
___Difficulty making decisions
___Low Energy
___Lack of appetite
___Shyness
___Premenstrual syndrome
___Empty nest
___Low self-esteem
___Bullying
___Feeling of being outside oneself
___Disorganized thoughts
___Pornography
___Peer pressure

Check any of the following that you experienced and indicate how recently

___Relationship issues/marital conflict ___________
___Separation/Divorce ___________
___Parental or family conflict ___________
___Depression ___________
___Sleep difficulties ___________
___Menopause ___________
___Violence in the home ___________
___Anxiety ___________
___Blacking out ___________
___Hearing voices ___________
___Sexual addiction ___________
___Weight gain or loss ___________
___Sexual issues ___________
___Infidelity ___________
___Pregnancy ___________
___Abortion ___________
___Manic Depression/Bipolar Disorder ___________
___Alcohol abuse/chemical substance use ___________
___Suicidal ideation ___________
___Homicidal ideation ___________
___Self-harm (e.g. cutting) ___________
___Hallucinations ___________

Have you experienced a psychiatric hospitalization? When, how long, reason for admission. ____________________________

____

____

Have you experienced other mental or emotional problems? Please specify. ____________________________________

____

____

Prescribing physician's name: ____________________________________ Date last seen: ____________________

Physician's address: ____Phone number: ____________________

Coordinating medical treatment is important for your overall benefit. Please indicate if I may contact your prescribing physician to coordinate your treatment. ☐ Yes ☐ No

Consenting signature: ____ Date: ____________________________

Spirituality

Do you consider spirituality meaningful to you? ____

Level of meaningfulness of spirituality now ___high ___medium ___low

Do you have a specific religious affiliation? ____

Additional information regarding your spiritual beliefs ____

____

Emergency Contact

Name ____Contact telephone number ____________________________

Relationship to you ____