CROSSROADS
COUNSELING & PSYCHOTHERAPY

Clinical History Form

Client Name: _____ **Birthdate (client):** _____

Please describe your Chief Complaint: _____

_____

_____

Was the onset: Sudden _____ Gradual _____

History of Presenting Problem(s) (include your symptoms, when they began, how often they occur, etc.)**:**

_____

_____

_____

_____

Safety, Suicide and Self-Harm History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **Are you currently feeling suicidal?** ☐ Yes ☐ No
2. **Are you currently afraid for your safety?** ☐ Yes ☐ No
3. **Have you ever tried to kill yourself?** ☐ Yes ☐ No
    a. If yes, how many times? _____
    b. If yes, was your intent to die? ☐ Yes ☐ No
    c. If yes, were you hospitalized ☐ Yes ☐ No
    d. If yes, was hospitalization helpful? ☐ Yes ☐ No
4. **Have you ever tried to self-harm?** ☐ Yes ☐ No
    a. If yes, how many times? _____
    b. If yes, please describe the most recent occurrence_____

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Past Psychological & Psychiatric Treatment History (Both Inpatient and Outpatient):

Provider or Facility	Dates of Treatment	Reason(s) for seeking treatment (symptoms & diagnosis)	Effective? Yes or No	How long did treatment last? How long did you see this provider?

Trauma & Abuse History: (physical/sexual/emotional/verbal abuse, loss, suicide, witness of domestic violence)

Nature of trauma/abuse	Time frame	Description, persons involved, etc.	Describe any treatment you received:

Family Psychiatric History:

Family Member (i.e., mother, brother, grandmother, uncle, cousin, etc.)	Psychiatric Problem(s) (i.e., depression, anxiety, bipolar, substance use, trauma, ADHD, etc.)

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Substance Use History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

Substance Used	√ if "Yes"	Still Using?	Age of first use	Age of last use	Amount per day	Days per month
Marijuana/Hashish/etc						
Opiates						
Prescription pain killers						
Heroin						
Cocaine						
Amphetamines/Speed						
Benzodiazepines						
Alcohol						
Others, please describe						

Consequences of Substance Use:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)
Please check all consequences that apply because of alcohol consumption or abuse of substances

- ☐ Felt that you needed to cut down on your drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needed a drink first thing in the morning
- ☐ Increased tolerance
- ☐ Blackouts
- ☐ Withdrawal sx (i.e., shakes, sweating, nausea, rapid heartbeat)
- ☐ Seizures
- ☐ Effects on physical health
- ☐ Using or consuming more than you intended
- ☐ Unintentional overdose
- ☐ DUI/DWI or Arrests
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work or school

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Medical Conditions & History: (past and present, use back if needed)

Medical Condition/Surgery	Treatment history	Was the condition resolved? Is it still problematic? Any other info?

Medications: (past & present – include prescribed, over-the-counter, herbal supplements & vitamins)

Medication	Dosage and Frequency	Dates Taken	Prescribed by	Effective?	If no longer taking, reason for stopping?

Current Living Situation: Other Family Members or Persons Living in the Home

Name	Is the person living inside or outside the home?	Relationship	Is the person biologically related? (Yes or No)	Gender	Age	Describe Job or Grade in school

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Biological Parents:

Please provide the following information about your biological parents (or your child's, if they are the client)	Mother	Father
Name		
Living or Deceased?		
Age (current or when deceased)		
Birthplace		
Occupation (current or previous)		
Number of hours away from home per day. (If not in the home, leave blank)		

Developmental & Educational History:
(If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **During your mother's pregnancy and your birth, did your mother have any problems with any of the following?** (check all that apply)

☐ Exposure to drugs or alcohol during pregnancy ☐ A difficult pregnancy

☐ Problems with delivery ☐ Exposure to cigarettes (direct/indirect)

☐ Any complications after your birth? (i.e., premature birth, jaundice, breathing difficulties)

Please describe: _____

2. **Did you have any delays or difficulties in reaching the following developmental milestones?**
(check all that apply)

☐ Walking ☐ Talking ☐ Toilet training

☐ Sleeping alone ☐ Being away from parents ☐ Making friends

3. **Which options below best describe your childhood home atmosphere?** (check any/all that apply)

☐ Normal ☐ Supportive ☐ Parental fighting

☐ Financial difficulties ☐ Parental violence ☐ Frequent moving

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4. Which of the following challenges did you experience during your childhood? (check any/all that apply)

- ☐ Tantrums
- ☐ Fighting
- ☐ Property damage
- ☐ Animal cruelty
- ☐ Depression
- ☐ Enuresis (bed wetting)
- ☐ Stealing
- ☐ Fire setting
- ☐ Victim of bullying
- ☐ Parental divorce
- ☐ Eating/weight issues
- ☐ Running away from home
- ☐ Separation anxiety
- ☐ Engaged in bullying
- ☐ Death of a parent/caregiver

5. Which of the following best describes problems you may have had in school? (check any/all that apply)

- ☐ Fighting
- ☐ Detentions
- ☐ School refusal
- ☐ Special education
- ☐ School phobia
- ☐ Suspensions
- ☐ Class failures
- ☐ Remedial classes
- ☐ Truancy
- ☐ Expulsions
- ☐ Repetition of grades

6. Did you have additional schooling outside of the standard classroom setting? (check any/all that apply)

- ☐ Speech classes
- ☐ Tutoring
- ☐ Accommodations

7. Please select your highest level of education

- ☐ Less than High School
- ☐ Two-year degree
- ☐ High School
- ☐ Four-year degree
- ☐ Some college
- ☐ Graduate degree

General Social History: (If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. Which options below best describes your social situation? (check any/all that apply)

- ☐ Family conflict
- ☐ Few friends
- ☐ No friends
- ☐ Supportive social network
- ☐ Distant from family of origin
- ☐ Substance-use based friends

2. What is your current marital status?

- ☐ Single, never married
- ☐ Divorced
- ☐ Married
- ☐ Widowed
- ☐ Committed relationship

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☐ Unemployed ☐ Employed part-time ☐ Employed full-time ☐ Retired ☐ Disabled
☐ Full-time student ☐ Part-time student

Lifestyle and Wellness History: (If you are filling this out on behalf of the patient, please answer from the patient's perspective)

1. **How many hours of sleep do you get, on average, each night?** ☐ 5h or less ☐ 6-7h ☐ 7-8h ☐ 8h+
   a. Do you have difficulty falling/staying asleep? ☐ Yes ☐ No
   b. If yes, explain:_____
2. **Do you exercise regularly?** ☐ Yes ☐ No
   a. If yes, how often? _____
   b. If yes, what form(s) of exercise do you do? _____
3. **How would you describe your nutrition?** ☐ Excellent ☐ Average ☐ Not great ☐ Terrible
   a. How many meals & snacks do you eat/day? _____
   b. Do you have any dietary restrictions or special diets (Gluten Free, Vegetarian, etc.?) ☐ Yes ☐ No
4. **What are your leisure and recreational hobbies?** _____
   _____
5. **Do you have any physical restrictions or disabilities?** _____
6. **How do you identify your gender?** ☐ Male ☐ Female ☐ Gender Fluid ☐ Other: (describe)_____
7. **How do you identify your sexuality?** ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Questioning
8. **Are you in a relationship?** ☐ Yes ☐ No ☐ Not Applicable (child)
   a. Are you satisfied with your relationship? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely
   b. Are you sexually active? ☐ Yes ☐ No ☐ Not Applicable (child)
9. **Is religion/spirituality important to you?** ☐ Yes ☐ No
   a. Do you participate in an organized religion? ☐ Yes ☐ No If yes, which one? _____
10. **How do you identify your race/ethnicity/cultural background?** _____

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11. Have you ever experienced discrimination, including sexism, racism, ageism, etc. ☐ Yes ☐ No

a. Please describe: _____

12. Do you have any past or present legal troubles? ☐ Yes ☐ No

a. If yes, any arrests? ☐ Yes ☐ No

13. What outcome do you most hope to get from therapy? _____

_____

Given the list of categories below, how much stress is each currently causing you?

	No Stress	Mild Stress	Moderate Stress	Severe Stress
Family				
Friends				
Relationships				
Educational				
Economic/Financial				
Occupational				
Housing				
Legal				
Health				

Is there anything else you want me to know? _____

_____