Kelly A. Martin Counseling, PLLC
Dba: Sonshine Soul-utions Counseling

Personal History – Adult:

Client name: _____ Date: _____

Gender: _____ Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (home/cell) _____

Alternate phone: _____ Email: _____

May I leave voice mail message on your phone(s)? Yes No

Emergency contact name: _____ Phone: _____

Primary reason(s) for seeking services: (Circle all that apply)

Addictive Behaviors	Alcohol/Drugs	Anger Management	Anxiety
Depression	Domestic Violence	Fear/Phobia	Family Issues
Grief	Marital Concerns	Post Trauma Stress	Pre-Marital Counseling
Relationship Issues	Sexual Assault	Other: _____	

Family Information – Living in Your Home:

Relationship	Name	Age

Other significant relationships in your life that need to be included or mentioned:

Relationship Name Age (Please note if deceased, and also cause of death)

_____

_____

_____

Marital Status:

Single Planning to marry/engaged In a dating relationship Divorce in Progress

Unmarried, living together Separated Divorced

Widowed Explanations: _____

_____

Assessment of current relationship (if applicable): Good Fair Poor In Danger

Parental Information (list parental figures in your life and any pertinent information about your relationship with them):

_____

_____

_____

Development: Are there special, unusual, or traumatic circumstances that affected your development? _____

If yes, please describe: _____

_____

Has there been a history of child abuse? Yes No

If yes, which type(s) Sexual Verbal Physical

If yes, the abuse was as a(n) Victim Perpetrator

Other childhood issues: Neglect Inadequate Nutrition Other: _____

_____

_____

Social Relationships - Check how you generally get along with other people: (Check all that apply)

Affectionate Aggressive Avoidant Argue/Fight Often

Follower Friendly Leader Outgoing

Shy/Withdrawn Submissive Other: _____

Sexual orientation - Heterosexual Homosexual Trans-gendered Bi-Sexual

Comments: _____

_____

Sexual dysfunctions: Yes No If yes, describe: _____

_____

_____

Any current or history as a sexual predator? Yes No If yes, describe: _____

_____

_____

Cultural/Ethnicity: To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic problems? Yes No

If yes, describe: _____

Spirituality/Religion: How important are spiritual matters to you? _____

Are you affiliated with a spiritual or religious group? Yes No

If yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into your counseling? Yes No

Comments: _____

_____

Legal Issues - Current Status: Are you involved in any active cases (traffic, civil, criminal) Yes No

If yes, please describe reason/charges: _____

Are you currently on probation or parole? Yes No

If yes, please describe: _____

_____

Past history – Criminal involvement:

Charge/Reason Date City Results

_____

_____

_____

Education - Highest level of education completed: _____

Special educational training/degrees/certifications: _____

_____

Comments: _____

_____

Employment - Describe most recent job and history:

Employer Dates Duties/Title Reason for Leaving

_____

_____

_____

_____

_____

Military - Yes No Combat experience? Yes No Where? _____

Branch: _____ Discharge Date: _____ Type: _____

Date enlisted: _____ Rank at Discharge: _____

Leisure/Recreational – Describe special areas of interest/hobbies: (art, crafts, sports, church, exercise, etc.)

Activity	How often now?	How often in past?
_____		
_____		
_____		
_____		

Medical/Physical Health – Put an "S" beside items that apply to you and an "F" applying to a family member.

_____AIDS/HIV	_____Nose Bleeds	_____Alcoholism	_____Epilepsy
_____Abortion	_____Allergies	_____Eating Problems	_____Sleep Disorders
_____Anemia	_____Surgery	_____Fatigue	_____Cancer
_____Headaches	_____Stroke	_____Tuberculosis	_____Hepatitis
_____Diabetes	_____Blood Pressure	_____Miscarriages	_____Mental Disorder
_____Loss of Hearing	_____Chronic Pain	_____Heart Attack	_____Vision Problems
_____Loss of Memory	Other: _____		

Please describe if necessary: _____

Current health concerns: _____

Current prescribed medications	Dose	Purpose	Side effects
_____			
_____			
_____			

Are you allergic to any medications or drugs?_____

Please circle if there have been any recent changes in the following:

Sleep Patterns	Eating Patterns	Behavior	Energy Level
Physical Activity Level	General Disposition (Mood)	Weight	Nervousness/Tension

Describe changes in areas checked above: _____

_____

_____

Chemical Use History: Method & Amount Frequency Age of 1st Use Date of Last Use

Alcohol: _____

Cocaine/Crack: _____

Heroin/Opiates: _____

Inhalants: _____

Marijuana: _____

Methamphetamines: _____

Prescription Drugs/Other Drugs: _____

Tobacco/Nicotine: _____

Substance Abuse Questions – Do you abuse or are you addicted to any substance? Yes No

If yes, describe: _____

_____

Counseling/Prior Treatment History – Have you ever sought counseling before? Yes No

If yes, what was the experience like for you? _____

_____

Have you ever experienced suicidal thoughts or attempted suicide? Yes No

If yes, please describe: _____

_____

Have you ever had any type of inpatient treatment (including drug/alcohol rehab)? Yes No

If yes, please describe: _____

_____

Do you have any family members or friends who have been treated for suicidality or addiction? Yes No

If yes, please describe:_____

_____

Please circle behaviors and symptoms that occur to you more often than you would like:

Aggression/Anger	Anxiety	Gambling	Sexual Addiction	Antisocial Behavior
Hallucinations	Worrying	Loneliness	Eating Problems	Withdrawing
Mood Shifts	Crying	Sickness	Avoiding People	Nightmares
Hopelessness	Chest Pains	Impulsivity	Depression	Suicidal Thoughts
Sexual Dysfunction	Panic Attacks	Drug Use	Judgment Errors	Irritability
Cyber Addiction	Memory Trouble	Other symptoms? _____		

Describe which symptom(s) impact you the most: _____

_____

What is your hope for coming to counseling? _____

_____

_____

Other information I need to know? _____

_____

_____

_____

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date

Client Concern Rating

Name: _____ **Date:** _____

Please list the most distressing concerns in your life that are affecting you as you enter counseling.

Next, rate these concerns by circling the number that best describes how much it is disrupting your life at the current time. Use the following scale:

"1" is a very low amount of disruption and/or concern. "10" is an extreme amount of disruptions and/or concern.

Your counselor will use this as a guide to evaluate your needs and goals for counseling and to prepare your treatment plan. As with all other information in your counseling process, this form is confidential.

Issue # 1 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme

Issue # 2 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme

Issue # 3 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme

Issue # 4 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme

Issue # 5 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme

Issue # 6 _____

Low 1 2 3 4 5 6 7 8 9 10 Extreme