Olive Branch Counseling and Training

31320 IH 10 West, Boerne, TX 78006
Office: (210) 564-4310 Fax: (830)755-2369

Personal History Intake Packet

Client Name: ____ Date: _______________

Gender: ☐ M ☐ F Date of birth: _____________________________ Age: ________________

Forms completed by (if someone other than client): ____________________________________

Address: ____________________________ City: ______________________ Zip: __________

Phone (home): _________________ Work: ___________________ Cell: ________________

Social Security Number: _____________________ * This is only necessary when filing with insurance.

Email Address: ____

May we contact you by: (please check all that apply)

☐ Phone call ☐ Leaving a voicemail message ☐Text Message ☐ Email ☐ U.S. Postal Mail

Emails

While every precaution is taken to ensure confidentiality on the internet, emails can be hacked and information can be seen by unwanted parties. Please initial to indicate your understanding of the associated risks with email communication and your acceptance of receiving emails. ________

Primary reason(s) for seeking services

☐ Addictive Behaviors
☐ Trauma History
☐ Anger management
☐ Anxiety
☐ Career/Education
☐ Grief & Loss
☐ Separation/ Divorce
☐ Other: _______________________________________
☐ Communication Skills
☐ Coping
☐ Depression
☐ Behavioral Concerns
☐ Fear/Phobias
☐ Giftedness
☐ Social struggles
☐ Personal Growth
☐ Parenting
☐ Relationship concerns
☐ Sexual Concerns
☐ Sleeping Problems
☐ For other family member
☐ Family Conflict

While I am happy to help, please know that a referral to a different counselor/therapist may be in order to best meet your needs. I will happy to help you set that up if necessary.

________Please initial here to indicate your understanding of the limits of my specialties and the ethical obligation to make referrals when there is a mismatch between need and services.

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Please indicate who the services are for: ____.

Relationship to you: _____ Self _____ Other __________________________________.

What are your goals for therapy? Please list them for your child if the services are for them.

____

____

____

Do you feel suicidal at this time? □ Yes □ No, if Yes, explain:

____

____

Have you experienced major changes/events during the past year? □ Yes □ No, if Yes, explain:

____

Are you presently seeing another counselor? □ Yes □ No, If Yes, Who? _________________________

Have you had previous counseling or psychotherapy? □ Yes □ No If Yes, please share when and for what reason.

____

____

<u>Behaviors/Symptoms</u> Check behaviors/symptoms that occur more often than you would like:

□ Anger/aggression	□ Fatigue	□ Panic Attacks
□ Alcohol/drug use	□ Gambling	□ Phobias/Fears
□ Anti-social behavior	□ Hallucinations	□ Recurring thoughts
□ Anxiety	□ Heart Palpitations	□ Sexual thoughts/acts
□ Avoidance	□ High blood pressure	□ Sexual difficulties
□ Chest pain	□ Hopelessness	□ Sick often
□ Critical of self/others	□ Irritability	□ Sleep problems
□ Cyber/internet use	□ Judgment errors	□ Suicidal thought
□ Depression	□ Loneliness	□ Thoughts disorganized
□ Disorientation	□ Memory impairment	□ Withdrawing
□ Distractibility	□ Mood shifts	□ Worrying
□ Elevated mood	□ Over/under eating	

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Education/ Career

Highest Degree: ___________________________ Occupation: ________________________

Degree in: ________________________________ Other: ______________________________

Military experience? □ Yes □ No If yes, please explain:

____

Family Information

*Note: Please include all people living in the home. You may use the back of the page if needed.

Relationship	Name	Age	Living? Yes	Living? No	Living with you? Yes	Living with you? No
Mother						
Father						
Spouse/Partner						
Child						

Please list significant others, siblings, grandparents, half-relatives, etc.						

Marital Status

□ Single
□ Married
□ Divorced/Divorce in process
□ Widowed

□ Living with significant other
□ Committed relationship, living apart
□ Separated
□ Other: ____

Family of Origin (the family the client was born into and/or raised with)

Parents:

□ Married/Together

□ Divorced/Separated

□ Mother remarried; Number of times: ______

□ Father remarried; Number of times: _______

□ Special circumstance (e.g. raised by person other than parents)

Please describe any special circumstances:

____

Development

Are there unusual or traumatic circumstances that affected your development? □ Yes □ No

If Yes, describe: ____

Is there a history of abuse? □ Yes □ No

If Yes, which type(s)? □ Sexual □ Emotional □ Physical □ Verbal

If Yes, the abuse was as a: □ Victim □ Perpetrator

Other childhood issues: □ Neglect □ Inadequate nutrition □ Other: _________________________

Cultural/Ethnic

To which cultural or ethnic group do you belong? ____

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

If Yes, please describe: ____

Other cultural/ethnic information you want to share:

____

Religious/Spiritual

How important to you are religion/spirituality? □ Not at all □ A little □ Moderately □ Very

Do you belong to a religious or spiritual group? □ Yes □ No If Yes, Which? ______________________

Do your religious or spiritual beliefs help you cope in life? □ Yes □ No If Yes, explain:

____

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

If yes, describe:

____

Support Network

My network of support and encouragement includes the following: (check all that apply)

□ Myself	□ Classmates	□ Colleagues	□ Neighbors
□ Exercise class/Partner	□ Online groups	□ Family	□ Friends
□ Religious/Spiritual Group	□ Social Networks	□ Other: ________________________________	

Recent changes to my support network include:

____

Medical/Physical Health

Do you have (or have a history of) medical problems in the following areas:

□ Neurological □ Abdominal pain or difficulties with elimination
□ Chronic Pain □ Musculoskeletal
□ Ear/Nose/Throat □ Skin
□ Cardiology □ Respiratory
□ Other: ____

Explanation if necessary:

____

____

Medical/Physical Health (*continued*)

List any recent health or physical changes:

____

____

Have you ever been hospitalized? □ Yes □ No If so, what? (Please list only those that occurred in the last 3 years or are related to your current issue or problem.)

____

____

Substance Use Questions

Do you drink alcohol? □ Yes □ No If Yes, how much? ____________________________________
Do you use illegal drugs? □ Yes □ No If Yes, what/how much? ______________________________

Describe when and where you typically use substances: _____________________________________

Describe how your use has affected your family and/or friends (include their perception of your use):
N/A_____

Explanation:____

____

Reasons for use:
□ Addiction □ Socialization
□ Escape □ Taste
□ Self- medication □ Other: ______________________________________

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Please read, initial, sign and date to complete the Client History Intake Packet.

Thank you for taking time to complete the Client History Intake Packet for me. While it is detailed and lengthy, please know it is necessary to have as much information as possible to get the best picture of your current circumstances so that an effective treatment plan can be put in place. As mentioned earlier, if there appears to be a mismatch in your needs and our services, we will be happy to assist you in seeking a professional who can support you and your therapeutic goals.

______ Please initial here confirming that the information in this packet is true and accurate to the best of your knowledge and you understand we may or may not begin working together based on the information found herein.

____ ___________________________
Client Signature Today's Date