CCM Counseling, PLLC

Client History and Information

Please answer the questions below as honestly and completely as possible so that I might know how to best support you on your journey. All your information will be kept strictly confidential.

Client's Name:_____ DOB: ___/___/___ Age: _____
☐ Male ☐ Female Marital Status: ☐S ☐M ☐D ☐W ☐Separated
Address: _____
Primary Telephone Contact: _____ Other: _____
Can I leave a message: ☐Yes ☐No
Email Address: _____

Emergency Contact: _____ Relationship: _____
Telephone: _____

Occupation/Employment:
_____

How did you hear about CCM Counseling? _____

Physical

Please list allergies or adverse reactions to food/medications:
_____

Are you currently under the care of a physician or other health care professional? ☐Yes ☐No
If yes, Doctor's name: _____ Specialty: _____
Issues Addressed: _____ Date of last visit: _____
Doctor's name: _____ Specialty: _____
Issues Addressed: _____Date of last visit: _____
Doctor's name: _____ Specialty: _____
Issues Addressed: _____ Date of last visit: _____

Please explain any significant medical problems, symptoms, or illnesses that may be impacting your mental/emotional health:

Current Medications/Supplements:

Please include over the counter medications and supplements

Medication/Supplement	Dosage	Purpose	Side Effects

Mental/Emotional

Reason for seeking psychotherapy/counseling:

What would you like to see different about yourself or your life as a result of being in therapy?

Previous psychiatric hospitalizations or inpatient treatment (Please list reason and dates):

Previous outpatient treatment (Please include names of providers, dates of care, and locations):

Past Psychiatric Medications:

Current Psychiatric Medications:

Prior Mental Health Diagnoses:

Which of the above has been helpful for you and why?

What has not been helpful and why not?

Current Symptoms: (Check all that apply)

- ☐ Long periods of sadness
- ☐ Loss of interest
- ☐ Physical pain
- ☐ Change in sleeping
- ☐ Nightmares
- ☐ Loss of time
- ☐ Substance Abuse
- ☐ Difficulty feeling emotions
- ☐ Intrusive memories
- ☐ Racing thoughts
- ☐ Startle easily
- ☐ Memory challenges
- ☐ Thoughts of suicide
- ☐ Self-harm behavior
- ☐ Difficulty concentrating
- ☐ Seeing things others don't
- ☐ Relationship difficulties
- ☐ Mood swings
- ☐ Panic Attacks
- ☐ Hearing voices
- ☐ Spacing out/blacking out
- ☐ Anger
- ☐ Difficulty naming feelings
- ☐ Feeling disconnected from self, others, or body
- ☐ Other symptoms:

Please briefly describe the family you grew up in:

Family history of behavioral health issues: ☐ Depression ☐ Anxiety ☐ Addiction
☐ Other:

Please briefly describe your current family:

Who provides you with emotional support?

Please describe your leisure, educational, and professional pursuits:

Are you now experiencing, or have you ever experienced, any of the following events?
If yes, please list when and by whom.

☐Yes ☐No Physical assault or abuse:

☐Yes ☐No Sexual assault or abuse:

☐Yes ☐No Emotional or verbal abuse:

☐Yes ☐No Parental neglect:

☐Yes ☐No Domestic violence:

☐Yes ☐No Violent crime:

☐Yes ☐No Participating in or witnessing combat:

☐Yes ☐No Ritual abuse or torture:

☐Yes ☐No Other Traumas (please list):

How do you believe these experiences have affected you?

I hereby certify that the content disclosed is accurate and complete to the best of my knowledge.

Client Signature *Date*