REGION II HUMAN SERVICES

Client History Questionnaire Date:_____

Client Information

Name: _____

Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Preferred Pronouns: _____

Emergency Contact: _____ Phone: _____

Reason for Visit

What brings you to counseling today?

What do you hope will be different after counseling?

Safety & Risk

☐Thoughts of suicide or self-harm

☐Suicide attempt(s)

☐Thoughts of harming others

☐History of violence or harming others

☐Current alcohol or drug use (list): _____

☐Past substance use treatment

Behavioral Health History

Ever hospitalized for mental health concerns? ☐Yes ☐No

Ever diagnosed with mental health or substance use disorder? ☐Yes ☐No

Past counseling or psychiatric care? ☐Yes ☐No

Physical Health

Primary Care Provider: _____

Last PCP Visit: _____

Last Dental Visit: _____

Current medical problems: _____

Current medications (or attach list): _____

Allergies: _____

Height: _____ Weight: _____

Activities of Daily Living (ADLs)

Do you have difficulty with:

☐Bathing/showering

☐Walking/mobility

☐Cooking/preparing meals

☐Managing money/finances

☐Remembering to take medications

☐Housekeeping or shopping

If yes, please describe: _____

Social Snapshot

Current living situation (who you live with): _____

Housing quality: ☐Good ☐Fair ☐Poor

Relationship status: _____

Children (names/ages): _____

Support system (people you can count on): _____

Trauma & Legal

History of abuse or trauma: ☐Yes ☐No

Current legal problems: ☐Yes ☐No

History of arrests or probation: ☐ Yes ☐ No

Symptom Checklist

In the past month, have you experienced any of the following more days than not? (Check all that apply)

Mood & Emotions:

☐ Feeling sad, down, or hopeless
☐ Feeling very irritable or angry
☐ Mood swings

Anxiety & Worry:

☐ Feeling nervous, anxious, or on edge
☐ Panic attacks
☐ Difficulty relaxing or sleeping because of worry

Thoughts & Perceptions:

☐ Racing thoughts or feeling "sped up"
☐ Seeing or hearing things others don't
☐ Feeling very suspicious or paranoid

Behavior & Functioning:

☐ Trouble focusing or remembering things
☐ Trouble controlling impulses
☐ Aggressive behavior

Daily Life Impact:

☐ Missing work/school because of symptoms
☐ Difficulty taking care of daily responsibilities
☐ Feeling unsafe at home or in relationships

Strengths & Needs

Your biggest strengths: _____

Your biggest needs or goals: _____

Additional Information

Anything else you would like your provider to know:

_____
_____
_____
_____