Jewish Family Service of Greater Dallas
An open door to all in need

CLIENT HISTORY FORM

Please provide the following information and answer the questions below.
Note: information you provide here is protected as confidential information.

DEMOGRAPHICS

Date ____ /____ / ____ Social Security #___________________________

Name: ____
(Last) (First) (Middle Initial)

Birth Date: ______ / ______/ ______ Age: ______

Home Phone: ___________________________________ May we leave a message? Yes No

Cell/Other Phone: ________________________________ May we leave a message? Yes No

Emergency Contact: Name_____________________________ Phone: _____________________________

PRESENTING PROBLEM

Describe the problems you are having and when they began:

____

____

____

____

What has contributed to your difficulty?

____

____

____

____

CLIENT HISTORY FORM

PERSONAL HISTORY

EDUCATION

Are you currently enrolled in school or training?

Yes No

Highest grade completed:________________________________

Did you have any problems in school?

Yes No

If so, please list:____

OCCUPATION

Occupation: ____

Place of employment: ____

How long have you worked there? ____

MILITARY HISTORY

Have you served in the military?

Yes No

If so, branch: ________________________________

Years served: __________ years

Type of discharge: _______________________

LEGAL

Have you **ever** been involved with the legal system (criminal. divorce, custody, civil, etc.)?

Yes No

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If so, in what way? ______________________________

Are you **currently** involved with the legal system (criminal. divorce, custody, civil, etc.)?

Yes No

If so, in what way? ______________________________

Do you have any criminal or civil cases curretly pending?

Yes No

Do you currently have a probation/ parole officer?

Yes No

If so, who? ______________________________

Do you anticipate any involvement with the legal system in the future?

Yes No

MEDICAL HISTORY

List allergies, serious illnessess (including infectious diseases), surgeries, injuries, hospitalizations, number of preganancies:

____

____

____

____

List both prescription and over-the-counter medications which you presently use for physical conditions:

____

____

CLIENT HISTORY FORM

My overall general health is *(please circle):*

Excellent Good Fair Poor

Is there a pattern of physical illness in your family?

Yes No

If so, what? ____

TREATMENT HISTORY

Have you been in counseling before?

Yes No

If so, with whom? ____

When? ______________

For how long? ____

What was the primary issue? ____

What was the outcome? ____

Have you been hospitalized for emotional problems or for alcohol/ drug treatment?

Yes No

If so, when? ____________________________

Where? ____

What was the outcome? ____

What medications have you taken in the past for emotional or mental problems?

____

What medications have you taken in the past for emotional or mental problems?

____

CLIENT HISTORY FORM

Is there a history of mental illness in your family?

Yes No

SOCIAL HISTORY

What are your major strengths?

____

____

What are your major weaknesses?

____

____

From whom do you get emotional support?

____

What have been the losses, changes, crises, and transitions in your life?

____

____

____

Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influemces your life?

Yes No

If so, what? ______________________________

Is there anything about your lifestyle that would be helpful for your counselor to know?

____

____

CLIENT HISTORY FORM

FAMILY HISTORY

Please fill out the following about members of the family **you grew up with** *(if not applicable, write N/A)*:

Family Member #1:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Family Member #2:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Family Member #3:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Family Member #4:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Family Member #5:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Family Member #6:

Name: ________________________ Age: _______ Relation: ______________________

How did you get along? ____

Did you live away from your parents during childhood?

Yes No

If so, what were the circumstances? ____

Your experiences while growing up can strongly affect your life. What experiences and events (discipline, favoritism, trauma, affection, lack of affection, etc.) have been important in your life?

____

____

____

Please fill out the following about members of your **present** household *(if not applicable, write N/A)*:

Family Member #1:

Name: ______________________ Age: ______ Relation: ____________________

How do you get along? ____

Family Member #2:

Name: ______________________ Age: ______ Relation: ____________________

How do you get along? ____

Family Member #3:

Name: ______________________ Age: ______ Relation: ____________________

How do you get along? ____

Family Member #4:

Name: ______________________ Age: ______ Relation: ____________________

How do you get along? ____

Family Member #5:

Name: ______________________ Age: ______ Relation: ____________________

How do you get along? ____

CLIENT HISTORY FORM

Please fill out the following about your **present and past** spouse(s) and significant partner(s) (*(if not applicable, write N/A)*:

Partner #1:

Name: ________________________ Time together: ______________________

Reason for ending the relationship: ____

Partner #2:

Name: ________________________ Time together: ______________________

Reason for ending the relationship: ____

Partner #3:

Name: ________________________ Time together: ______________________

Reason for ending the relationship: ____

Partner #4:

Name: ________________________ Time together: ______________________

Reason for ending the relationship: ____

Please fill out the following about any children **not** living with you (*(if not applicable, write N/A)*:

Child #1:

Name: ________________________ Age: _______ Where they live: ______________________

How do you get along? ____

Child #2:

Name: ________________________ Age: _______ Where they live: ______________________

How do you get along? ____

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Child #3:

Name: ________________________ Age: _______ Where they live: ______________________

How did you get along? ____

Child #4:

Name: ________________________ Age: _______ Where they live: ______________________

How do you get along? ____

CONCERNS

Have you or any of the above relationships (family growing up, current household, children, partners), ever experienced any of the following problems *(please circle one on each row)*?

Mental Illness	Yes	No	If yes, who?____________________________________
Depression	Yes	No	If yes, who?____________________________________
Neglect	Yes	No	If yes, who?____________________________________
Sexual Dysfunction	Yes	No	If yes, who?____________________________________
Financial Difficulty	Yes	No	If yes, who?____________________________________
Emotional Abuse	Yes	No	If yes, who?____________________________________
Physical Abuse	Yes	No	If yes, who?____________________________________
Sexual Abuse	Yes	No	If yes, who?____________________________________
Alcohol Abuse	Yes	No	If yes, who?____________________________________
Drug Abuse	Yes	No	If yes, who?____________________________________
Other: _____________________			Who? ____

Were there sexual behaviors or comments during your childhood which made you uncomfortable?

Yes No

CLIENT HISTORY FORM

POSSIBLE ISSUES

SUBSTANCE USE

Please check all the substances you have used, past and present:

	PAST	NOW		PAST	NOW
Alcohol	☐	☐	Other Opiates (Vicodin, Darvocet, Percodan, Oxycontin, etc.)	☐	☐
Nicotine	☐	☐			
Marijuana	☐	☐	Depressants (Valium, Xanex, Rohypnol, Ativan, Klonopin, GHB, Quaaludes)	☐	☐
Crack/ Cocaine	☐	☐			
Heroin, Chiva	☐	☐	Caffeine	☐	☐
LSD, PCP, Ketamine	☐	☐	Inhalants	☐	☐
Ecstasy	☐	☐	Other _______________	☐	☐
Amphetamines	☐	☐			

When did you first use these?

____

How often do you use these?

____

How much do you use?

____

When did you last use?

____

CLIENT HISTORY FORM

SUICIDE AND HOMICIDE

Have you ever or do you now have:

	PAST	NOW
Thoughts of hurting yourself?	☐	☐
Thoughts of committing suicide?	☐	☐
Plans to commit suicide?	☐	☐
Attempts to commit suicide?	☐	☐
Threats to commit suicide?	☐	☐
Mutilated yourself?	☐	☐

	PAST	NOW
Thoughts of harming someone?	☐	☐
Plans to harm someone?	☐	☐
Attempts to harm someone?	☐	☐
Threats to harm someone?	☐	☐
Actually harmed someone?	☐	☐

DEPRESSION

Have you ever or do you now have:

	PAST	NOW
Inability to sleep or sleeping longer?	☐	☐
Increased or decreased appetite?	☐	☐
Tearfulness or feelings of despair?	☐	☐
Lack of energy or feelings of fatigue?	☐	☐
Preoccupation with life events?	☐	☐
Decreased contact with others?	☐	☐
Decreased interest in sex?	☐	☐
Feelings of depression?	☐	☐
Decreased interest in pleasurable of activities?	☐	☐

CLIENT HISTORY FORM

SPECIAL NEEDS

Do you have special needs in any of the following areas?

Diet	Yes	No
Transportation	Yes	No
Physical Disability	Yes	No
Medication	Yes	No
Reading/ Writing	Yes	No
Other: ____________________	Yes	No

OTHER

Is there anything else that might be helpful for your counselor to know that has not been asked?

____

____

____

____

____

____

____

YOUR SIGNATURE: ____ DATE: ___________________