LUTHERAN COUNSELING SERVICES, INC
CLIENT BACKGROUND INFORMATION

This will be a part of your Permanent Record

Please provide the following background information about you and your family. This information will help the therapist better understand what problems you are having and how to help change them. This information is confidential and will not be released to anyone without your written permission.

Name: ____ Date ________________

Address: ____

Home Telephone: __________________________________ Birth date: _____________________

Please briefly describe what issues have brought you to counseling at this time: _______________

____

____

____

Please use a check mark to indicate which of the following issues apply to you:

____ Depression
____ Suicidal Thoughts
____ Suicidal Actions
____ Anxiety/Fears/Worries
____ Panic Attacks
____ Anger/Temper Problems
____ Alcohol/Drug Abuse
____ Job/School Problems/Unemployed
____ Financial Concerns
____ Legal Problems
____ Major losses/Difficult Changes
____ Eating Disorder

____ Death of a Loved One
____ Parent/Child Conflict
____ Marital/Relation Issues
____ Sibling Issues
____ Violence in the Family
____ Communication Issues
____ Sexual Issues
____ Sexual Abuse/Childhood
____ Physical Abuse
____ Low Self-Esteem
____ Compulsive Gambling

ANY PROBLEMS WITH COPING OR THESE ACTIVITIES?:

____ Sleep Problems
____ Moody or crying more than usual
____ Feelings of guilt, worthlessness, hopeless
____ Fatigue, low energy
____ Hyper, too much energy
____ Loss of interest in things
____ People are out to get me
____ Disturbing thoughts I cannot stop
____ Change in appetite
____ Difficulties concentrating
____ Problems remembering things
____ Withdrawing from others
____ Repeated actions that I cannot stop

LIFESTYLE INFORMATION:

1. Please indicate if you consume any of these items and at what frequency:

	Daily	Weekly	Sometimes	Never
Tobacco	____	_____	_______	_____
Caffeine	____	_____	_______	_____
Alcohol	____	_____	_______	_____
Marijuana	____	_____	_______	_____
Other Drugs	____	_____	_______	_____

Please specify other drugs:

____

____

WORK HISTORY (list most recent first):

Title/Description	Company	Dates	Full/Part-time

RELATIONSHIPS:

With whom do you currently live?

____

Please list significant relationships and/or marriages:

Name of Partner	Married/Reside With – Length of Time	Names and Ages of Any Children

SOCIAL SUPPORT SYSTEM (someone that you can talk with):

Please check items that apply to you:

____ Friends

____ Family members

____ Church

____ I do not talk to others easily/I find it difficult to "open up"

FAMILY HISTORY:

Father's Name ______________________________________Age _____ Living ___ Deceased ___

Mother's Name _____________________________________ Age _____ Living ___ Deceased ___

Birth Parent's Marital Status (Married/Divorced) _________________________

Other caregivers' names and relationship (If not raised by birth parents):

____

Describe your current relationship with your parents: ____

____

Brother(s)/Sister(s):

Name ____ Age _____ Living ____ Deceased ____

Name ____ Age ______ Living ____ Deceased ____

Name ____ Age ______ Living ____ Deceased ____

Name ____ Age ______ Living ____ Deceased ____

(If more space is needed use other side of page)

Describe your current relationship with your siblings: ____

____

SCHOOL HISTORY: Highest Grade (or degree) Completed __________

If you did not complete a grade/program, why? ____

____

Any problems? ____

In your family, has anyone ever been diagnosed and/or treated for the following:

_____ Schizophrenia (who?) ____

_____ Major Depression (who?) ____

_____ Manic-Depressive Disorder (who?) ____

_____ Alcoholism/Drug Abuse (who?) ____

_____ Suicide Attempts (who?) ____

_____ Other: What and who? ____

MEDICAL HISTORY:

1. Please mark any of the following medical conditions that apply to you:

Asthma Diabetes Ulcers Migraines Epilepsy Seizures Headaches

Lupus Stroke Cancer Heart Condition Multiple Sclerosis

Gynecological Problems Menopause PMS Head Injury Thyroid Problem

"Other" (Please specify) ____

Any Allergies or Drug Sensitivities? ____

. 2. The following is a medical screen to determine the need for medical services. Within the past 30 days, have *you* experienced any *of* the following symptoms?

Recent head injury	___ yes	___ no
Convulsions or seizures	____ yes	____ no
Unconsciousness/Fainting	____ yes	____ no
Disorientation as to time, place, person	____ yes	____ no
Hallucinations, delusions, illusions	____ yes	____ no
Unusual and/or heavy bleeding	____ yes	____ no
Persistent Pain	____ yes	____ no
Shortness of Breath	____ yes	____ no
Persistent Chest Pain	____ yes	____ no
Severe Vomiting	____ yes	____ no
Severe Headache w/blurred vision	____ yes	____ no
Untreated Fractures	____ yes	____ no

3. Name and address of personal physician: ____
____

4. Current prescriptions/medications: ____
____
____

5. List any major health problems in your family's past: ____________________________________
____
____

PREVIOUS COUNSELING OR INPATIENT TREATMENT/HOSPITAL:

Name of Therapist or Agency/Hospital | Date and Focus of Treatment

____
____
____

Please list the things/events/issues that are creating stress in your life at the present time:

1. ____
2. ____
3. ____
4. ____

Please list any significant events or traumatic events that you have been through in your life:

____
____
____

CURRENT FUNCTIONING:

Place an "X" on the following scale to indicate how well you are coping with things at the present time. 100% means you are coping the best you ever have.

____
0 10 20 30 40 50 60 70 80 90 100

Counseling Goals:

Please list the goal(s) you hope to achieve in counseling. (Be specific):

1. ____
2. ____
3. ____

Name the top three things important to you in choosing a therapist:

1. ____
2. ____
3. ____

How did you get my name?

____