Kara Fleming, LPC
Mind Body Counseling & Fitness
128 S. Euclid Ave. 2nd Floor Suite 3C
Westfield, NJ 07090
(908)-578-7857

Client History and Information

Basic Information Date:_____

Patient Name:_____

Date of Birth: _____ Gender: [ ] Male [ ] Female

Home Address: _____

Home Phone Number: _____Work Phone Number:_____

Mobile Phone Number:_____May we leave a message? [ ] Yes [ ] No

Email Address:_____
(Please print clearly, this is the address where your bill will be sent and other important correspondence will occur)

If the above patient is a minor complete the following:

Name of Guardian: _____

Address of Guardian: _____

Guardian's Home Phone:_____ Guardian's Work Phone: _____

Guardian's Mobile Phone: _____ May we leave a message? [ ] Yes [ ] No

Referral Source Who referred you to our office, or how did your learn about our practice? _____

Emergency Contact Information

In case of an emergency, whom should we contact?

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

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History Information

Who is providing the history information?

[ ] The patient [ ] The patient's guardian [ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words.

_____

_____

_____

_____

How long have you experienced this problem, or when did you first notice it?

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem

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[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tensions, aches, etc.
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Paranoid thoughts/Thoughts that someone is watching you or going to hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated
[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)
[ ] Distorted body image
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy?[ ] Yes [ ] No

What did you like/dislike about previous treatment?

_____

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

Suicidal Ideation:

Are you currently experiencing thoughts of harming either yourself or someone else?

[ ] Yes [ ] No If yes, explain: _____

_____

Have you in the past experienced thoughts of harming either yourself or someone else?

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[ ] Yes [ ] No If yes, explain: _____

_____

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? [ ] Yes [ ] No

If yes, explain:

Did you know if you walked, talked, and read on time? [ ] Yes [ ] No

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? _____

Are you satisfied at where you are in your life? _____

If not, where would you like to be? _____

Medical History

List any current or important past medications

Medication & Dose:_____Response to Medication: _____

History of serious childhood illnesses: _____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime: _____

Have you experienced any head injuries? [ ] Yes [ ] No

If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No

If yes, did you also have a fever? [ ] Yes [ ] No

Explain any allergies you have: _____

How would you rate your current physical health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health "check up?" _____

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Who is your primary care physician?

Name _____ Phone # _____

Address _____

Family History

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Stepfather

[ ] Other: _____

Relationship with parent figures: (good, fair, poor, close, distant, etc.)

Mother:

Father:

Step-parent:

Other:

List your siblings, their ages and gender and describe your relationship with them:

_____

_____

_____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

_____

Any family history of substance abuse, mental illness, suicide, or violence?

_____

Any Additional Family Information you feel is important to share:

_____

Social History

Describe your relationship with peers and/or friends? _____

_____

On a scale of 1-10 rate the quality of your social life.

1	2	3	4	5	6	7	8	9	10
Poor			Fair			Good			Great

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Describe your hobbies/interests: _____

Describe any cultural concerns: _____

_____

Educational History

When attending school were you:

[ ] In regular classes [ ] Home Study [ ] Special classes [ ] advanced classes

[ ] Ever suspended [ ] Placed in alternative school

What is the highest educational level you have completed? _____

Give any additional important educational information (i.e. did you like school? Have a learning disability?) _____

Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed [ ] Self-employed

[ ] Student [ ] Other

Are you satisfied with your employment? [ ] Yes [ ] No

If not, why? _____

Marital History

Which best describes your marital status?

[ ] Married, Date: _____ [ ] Never Married [ ] Widowed, Date: _____ [ ] Separated, Date: _____ [ ] Divorced, Date:_____

If you are married, please briefly describe nature of your marital relationship:

_____

If you are married, which best describes your marital satisfaction?

[ ] Poor [ ] Fair [ ] Good [ ] Great

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Please list any previous marriages/significant relationships including current:

Name _____

Date _____

Nature of Relationship _____

Do you have children? [ ] Yes [ ] No

If yes, complete the following:

First Name(s)_____

Age(s)_____

Nature of Relationship(s)

_____

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Does your family currently have Child Protective Services Involvement? [ ] Yes [ ] No

If yes please complete the following:

Case Worker's Name: _____ Phone: _____

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other) [ ] Yes [ ] No

If you answered yes, please complete the following substance abuse history chart.

Substance	Age of first use	Frequency of use	Amount used	How did you use?(smoke, inject, etc.)

Circle the drugs you've tried or currently use (if any): Alcohol, Marijuana, Cocaine or Crack, Heroin, Amphetamines, Club Drugs (Ecstasy, Inhalants, etc.), Pain Medication

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(Oxycontin, Vicodin, etc., Benzodiazepines, Hallucinogens

Other: _____

Have you ever received treatment for a substance abuse issue? [ ] Yes [ ] No

If yes, please provide the name of treatment program: _____

Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization,

Halfway House, Recovery House, Counseling, Methadone, Suboxone)

Date of Treatment (Month, Year) _____ Outcome (Any Clean time?)

_____

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Are you on probation? [ ] Yes [ ] No

Name of Probation Officer and County: _____

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No:

If yes, please list the dates of your arrests/convictions:

_____

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

Additional Information

Summarize your goals for counseling/therapy:

_____

What expectations do you have for counseling/therapy?

_____

Name 5 things you would like to change about yourself.

_____

What are your strengths?_____

What are your weaknesses?_____

Is there any additional information that you believe it is important for your counselor to

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know in order to provide you with the best care possible?

_____

_____ _____

Signature of client or guardian Date