Manifest Counseling Collective

Client Demographics and History Summary

First Name: _____ Middle Name: _____ Last Name: _____ Date of Birth: _____

Preferred Name: _____ Preferred Pronoun: _____ Social Security #: _____

Parent/ Guardian Name: _____ P/G Contact #: _____

Insurance Company: _____ Member ID#: _____
(Please provide a photocopy of your insurance card, if appropriate).

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work or Other Phone: _____ Email address: _____

Best phone number? _____ Is it okay to leave you a voicemail? _____ email? _____ text? _____

Emergency Contact Name/ Phone Number/ Relation: _____

How were you referred? _____

What brings you here? What do you hope to accomplish through counseling? _____

_____

_____

Have you been previously diagnosed with any medical or mental illnesses? If so, which ones? _____

_____

Do you have any allergies? _____ Primary care physician name/ #: _____

Do you have any Case Management Needs? Housing/ Income/ Vocational/ Educational/ Court Assistance/ Other
If so, please explain: _____

_____

Are you currently working with law enforcement, other current mental health care, psychiatrist, or other social agency? If so, please explain and list. _____

_____

Please list any current medications and dosages: _____

_____

_____

Symptom Checklist

Please circle all that apply under each category. Space is provided for you to add comments.

Anxiety: **worry/ fears/ phobias/ restlessness/ bad nerves/ poor appetite/ insomnia/ nightmares/ flashbacks/ panic attacks/ repetitive thoughts or actions/ racing mind or thoughts/ other:** _____

Comments: _____

_____

Depression: **unhappy/ irritable/ moody/ low motivation/ feelings of guilt or shame/ sadness/ hopelessness/ overwhelmed/ grieving/ insomnia/ excessive sleep/ always tired or sluggish/ crying excessively/ loss of interest in previous activities/ low self-esteem/ withdrawing/ isolation/ poor concentration/ change in appetite/ weight loss or weight gain/ other:** _____

Comments: _____

_____

Emotions: **change quickly/ rapid cycling/ hard to control/ difficult to cope/ crying daily/ feeling numb/ multiple ups and downs throughout week/ affecting daily functioning or relationships/ other:** _____

Comments: _____

Self Control: **poor impulse control/ outbursts/ acting out/ risk taking/ violent toward self / violent toward others/ substanc abuse/ substance dependence/ chronic relapse on drugs or alcohol/ overeating/ too active/ sexually acting out/ temper tantrums/ other:** _____

Comments: _____

Relationships with others: **trouble communicating/ unassertive/ too assertive / passive-aggressive/ problems "getting along"/ not enough supportive relationships/ codependence/ unsatisfied with current relationships/ trouble maintaining friendships/ positive supportive relationships/ satisfied with current relationships/ able to sustain long-term relationships/ other:** _____

Comments: _____

Additional observations not covered above*:* _____

_____

Suicidal Ideation: **no current thoughts/ no history of suicidal thoughts/ current suicidal thoughts/ recent suicidal thought past suicidal thoughts/ no current plan/ current plan/ other:** _____
Past plan or attempt(s)? _____
History of or current self-harm? _____
History of family suicide/ experienced recent suicide of friend or family member/other: _____

Comments: _____

History of or Current Substance Use/ Abuse/ Dependence: _____

_____

_____

Do you have any significant family of origin issues to explore? Family members with mental health diagnoses, addiction history, abuse (direct/ indirect, physical, sexual, emotional, etc.): _____

_____

_____

Please describe significant events from your childhood, with specific focus on the following:

Conception, gestation, and birth: _____

Siblings and their ages: _____

What each parent was like during childhood: _____

_____

Your relationship with each parent during childhood: _____

_____

Your parents' relationship with each other: _____

_____

Any other significant relationships if relevant (e.g., grandparents, caretakers): _____

_____

Childhood traumas, upsets, issues: _____

_____

Childhood medical history including gestation, birth, vaccinations, illnesses, allergies, broken limbs, etc: _____

_____

_____

Childhood developmental issues, learning disabilities, if any: _____

Childhood spiritual history, if any: _____

Please describe significant events from your adulthood, with specific focus on the following:

Complete adult medical history, including illnesses, allergies, diseases, accidents, injuries, broken bones, surgeries, etc: _____

_____

Current sexual concerns, relationship difficulties, identity issues, or other significant relational observations:

_____

_____

Complete adult spiritual history: _____

_____

Adult traumas and issues: _____

_____

The themes and issues you specifically want to work on: _____

_____

Please briefly describe any previous therapy experiences or treatment you have received before now (positive, negative, or neutral), and include how they ended. _____

_____

_____

What strengths do you possess that will help in this therapeutic process? _____

_____

_____

Who would you consider to be a part of your support system?_____

_____

How will you know when things are getting better? _____

_____

_____

How do you feel about dogs? Any objections to having a therapy-dog-in-training sit in on your session? _____

_____

Anything Else? _____

_____

Client Signature **Date**

Therapist Signature **Date**