

Each individual who will be attending the sessions must complete a separate copy of this form.
If more space is needed, please use a blank piece of paper

PART B – CLIENT HISTORY INFORMATION

1. Have you had counseling before? yes; no. If yes, when, and with whom? _____

2. Have you been treated for any medical condition within the last 5 years? yes; no.
If yes, for what condition? _____

Who were you treated by, and for how long? _____

3. Are you taking any prescribed medications? yes; no. If yes, please list:

Name of medication	Dosage	Frequency

Prescribing doctor is your: primary care physician; psychiatrist; other.

Prescribing doctor's name: _____

4. Are you taking any non-prescription, over-the-counter medications? yes; no.

If yes, please list name, dosage, and frequency: _____

5. Do you have any allergies? yes; no. If yes, please describe: _____

6. Have you ever been treated or counseled for abuse of any mood-altering substance?

yes; no. If yes, when and with whom? _____

7. Have you ever had someone close to you (family member, friend, co-worker) suggest that you may have a problem with any mood-altering substance such as alcohol, drugs, etc? yes; no.

Signature

Date

Signature

Date

Parent or guardian signature required if client is not of legal age.