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INTAKE PERSONAL HISTORY

Client Name: _____ Date: _____

Marital Status: _____ Previous Marriage/Partner #: _____ Children: ___ Yes ___ No How many? _____

Please list all persons living in the same household:

Name	Age	Relationship	Name	Age	Relationship

Current medical problem(s) and medication(s) (include herbal, supplements, over-the-counter, dosage and starting dates):

_____

_____

_____

Previous surgery (type, approximate date(s)): _____

_____

_____

Trauma, accidents, losses (type, approximate date(s)): _____

_____

_____

_____

Names of previous counselors seen and approximate dates: _____

_____

Reason for seeking counseling/current concern(s): _____

_____

_____

_____

What is your occupation? _____

Do you smoke? If so, How many and how often? _____

_____

Alcoholic beverages, how many? _____ day/week/month. What type? _____

Recreational drug use? How much? _____

What type? Past? _____

Current? _____

Are there any types of addictive behavior in which you engage that you or the significant others in your life are concerned about?

_____

_____

Do you have a current spiritual practice? If so, describe _____

Do you have a previous spiritual practice? If so, describe _____

How did you find out about Changing Perspectives? _____