St. Louis CENTER FOR Family Development LLC

Client ID# _____

CLIENT HISTORY
ADULT (Age 18 and over)

CLIENT DEMOGRAPHICS					
Name			**Date of Birth**		
Home Address					
City		**State**		**Zip Code**	
Home Phone			**Cell Phone**		
Is it OK for therapist to leave a message at these numbers?				Yes No	
Name of Spouse/ partner			**Marital Status**		
Emergency Contact: Name & Phone Number					
How did you hear about STLCFD?					

Your treatment goals are of highest importance to us. Please complete the following questions; your therapist will discuss these with you during your first visit.

Reason for coming to St. Louis Center for Family Development (STLCFD)?

Why are you coming to treatment <u>now</u>?

What would you like to be different after treatment here?

Strengths & Abilities: Your assets, natural positives (examples: good support system, I'm motivated, coping skills, etc) and your skills, capabilities, competencies and talents (e.g., capacity to learn, common sense, academic intelligence, social skills, creativity, etc).

Needs: Specific things that will make treatment here successful (e.g., figuring out consistent transportation, prioritizing therapy, accessibility of services re: disability, support of family, etc).

Preferences: Things that will *enhance* your treatment experience (e.g., trying therapy with or without psychiatric medications, type of therapy, type of therapist, appointment times/day, etc).

Barriers: What might get in the way of achieving your goals?

What have you already done or tried to do to address the goals that bring you here today?

EDUCATIONAL & VOCATIONAL INFORMATION

Schools/Colleges attended

School/College Name	Diploma/Degree or years attended	Area of Study

Comments:

EMPLOYMENT HISTORY (please include the past 3 years)

Job Title	Organization	Length of Time	Reasons for Leaving

Are you satisfied with your current employment? **Yes** **No**

Comments:

MILITARY SERVICE Yes No

If yes, please specify

Rank	Branch	Saw Combat	Discharge Year	Honorable discharge?
		Yes No		Yes No

RELIGION/SPIRITUALITY

Protestant Catholic Jewish Buddhist Hindu Muslim Evangelical Agnostic Atheist Other_____

Presently active in religion/spirituality? Yes No N/A Satisfied with religion/spirituality? Yes No

Comments:

LEGAL INFORMATION

Have you (currently and/or in the past):
Had difficulty or contact with police?
Been convicted of a crime?
Been on probation?
No history of legal problems

Please describe present legal difficulties below:

LEISURE ACTIVITIES

Please list your leisure activities (hobbies, activities used for stress relief, tasks you enjoy in your spare time):

Are you satisfied with these activities (e.g., frequency, enjoyment, etc)? Yes No

What activities would you like to do more of / activities you have stopped / activities you have reduced?

CURRENT SYMPTOMS

Difficulty sustaining attention		Interrupts others		Excessive Worry		Racing thoughts	
Careless mistakes		Restlessness		Sadness		Decreased need for sleep	

Difficulty listening		Easily fatigued		Hopelessness		Exposure to traumatic event(s)	
Difficulty following instruction		Difficulty concentrating		Excessive guilt		Recurrent or intrusive thoughts	
Difficulty with organization		Irritability		Suicidal thoughts		Distressing dreams of the event	
Often lose items		Muscle tension		Sleep disturbance		Flashbacks	
Forgetful		Frequent headaches		Changes in appetite		Difficulty falling/staying asleep	
Fidgety		Frequent Stomachaches		Agitation		Startle Easily	
Often "on the go"		Vomiting		Decrease in pleasurable activities		Difficulties with spouse/ partner	
Talk excessively		Diarrhea		Extreme energy		Difficulties with family and/ or friends	

SUBSTANCE USE: Please complete the chart below and circle any of the substances listed if you have used them in the past 48 hours.

Specify Drug of Preference			**Specify Alcohol of Preference**						
			Please complete these questions for substances you currently use						
Category of Substance	Current Use?	Ever used?	Amount and Frequency of Use (e.g., 8 beers/day)	How often do you have strong urge to use? (hourly, daily, every other day, etc.)	Use has led to problems (social, healthy, legal, work)	Don't do what's expected of me due to use	Others express concern about my use	Have tried to cut down or stop	With-drawal symptoms
Alcohol	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Stimulant	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Cocaine	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Tranquilizer	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Barbiturate	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Marijuana	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Opioid	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Hallucinogen	N Y	N Y			N Y	N Y	N Y	N Y	N Y

Prescribed	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Nicotine	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Caffeine	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Other	N Y	N Y			N Y	N Y	N Y	N Y	N Y

Do you use Drugs / Alcohol in combination? No Yes

If YES, describe below:

Ever treated for alcohol or drug poisoning? No Yes	**Number of blackouts?**

Twelve Step (e.g., Alcoholics Anonymous) or other addiction group attended? No Yes

FAMILY HISTORY OF MENTAL HEALTH ISSUES

PAST EXPERIENCE IN TREATMENT

When	Who	What you liked	What you didn't like

CURRENT MEDICAL CONDITIONS

Condition	Treating Doctor

CURRENT MEDICATIONS	
Medical	**Psychiatric**

ADDITIONAL INFORMATION (You think therapist should know.)

11.12