St. Louis CENTER FOR Family Development LLC

Client ID# _______________

CLIENT HISTORY
ADULT (Age 18 and over)

CLIENT DEMOGRAPHICS			
Name		**Date of Birth**	
Primary phone #:			
Emergency Contact: *Name and Phone number*			
How did you hear about STLCFD?			
Please answer the following questions:			
What is your reason for coming to St. Louis Center for Family Development (STLCFD)?			
When did you first start to have concerns?			
What are 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)?			
What are specific things that will make treatment here successful (e.g., figuring out consistent transportation, type of therapist, accessibility of services re: disability, support of family, etc)?			

PREVIOUS COUNSELING/PSYCHOTHERAPY				
Have you ever been seen previously for evaluation and/or treatment of emotional or behavioral concerns?			☐ Yes ☐ No	
Check if applicable	☐ Psychiatric Treatment	☐ Counseling	☐ Group Therapy	☐ Family Therapy
	☐ Substance Abuse Treatment	☐ Partial Hospitalization	☐ Intensive Outpatient Program	☐ Inpatient

Age	Name of Provider/Facility	Reasons for Going	Progress Noted (no change, better, worse)

Have you ever tried to end your life with suicide?	☐ Yes ☐ No	Date of most recent attempt: ___________ Date of most severe attempt: ___________
Have you ever intentionally harmed yourself?	☐ Yes ☐ No	Date of most recent episode: ___________
If yes, how frequently do you engage in self-harm behavior (e.g., daily, weekly, monthly, etc.)?		
Have you had any history of violent behavior?	☐ Yes ☐ No	

HEALTH INFORMATION	
Please list all past and current medical conditions: ☐ Check if no past or current conditions	
Condition	**Treating Doctor**
Have you experienced any medical procedures, surgeries, or invasive treatments?	☐ Yes ☐ No
If yes, please describe:	
Do you have any disabilities not noted thus far?	☐ Yes ☐ No
If yes, please describe:	

MEDICATION

Are you currently taking psychiatric medications?	☐ Yes ☐ No
If yes, please provide the provider's name and phone number:	**Name:** ______________________________________ **Phone:** ______________________________________

Please list all current medications (both psychiatric AND medical):

Medication	Dosage	Progress Noted (no change, better, worse)

FAMILY INFORMATION

Current Living Situation: Please provide information for household/family members you currently live with.

Name	Relationship	Gender	Age	Comments

Do you have any family members with a history of mental health concerns?	☐ Yes ☐ No

If yes, please describe:

Do you have any family members with a history of medical concerns?	☐ Yes ☐ No

If yes, please describe:

TRAUMA HISTORY

Have you experienced any of the following:

- ☐ Death of family member and/or significant person
- ☐ Physical abuse
- ☐ Sexual abuse or sexual assault
- ☐ Emotional abuse
- ☐ Neglect
- ☐ Exposure to violence
- ☐ Serious accident
- ☐ Significant illness or injury
- ☐ Natural disaster (e.g., fire, tornado, earthquake)
- ☐ Other traumatic event: ______________________
- ☐ None

EDUCATIONAL & VOCATIONAL INFORMATION		
Are you currently a student?	☐ Yes ☐ No	If yes, where do you attend? ___________________________ what is the most recent year you completed? _______

If you are not currently a student, what is your highest level of education (e.g., high school, some college, etc.)?

What is your current employment status (e.g., employed full time, homemaker, disability, etc.)?

Has your mental health ever impacted your educational or employment status? If yes, please describe.

Have you ever served in the military?	☐ Yes ☐ No

RELIGION/SPIRITUALITY

☐ Protestant ☐ Catholic ☐ Jewish ☐ Buddhist ☐ Hindu ☐ Muslim ☐ Evangelical ☐ Agnostic

☐ Atheist ☐ Other_________________________

Presently active in religion/spirituality? ☐ Yes ☐ No ☐ N/A

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:

LEISURE ACTIVITIES

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

SUBSTANCE USE: Please complete the chart below			
Category of Substance	Current Use?	Ever used?	Amount and Frequency of Use (e.g., 8 beers/day)
Amphetamines/Speed	☐Y ☐N	☐Y ☐N	
Barbituates/Downers	☐Y ☐N	☐Y ☐N	
Opiates	☐Y ☐N	☐Y ☐N	
Cocaine	☐Y ☐N	☐Y ☐N	
Psychedelics (LSD, Ectstasy, etc.)	☐Y ☐N	☐Y ☐N	
Inhalants	☐Y ☐N	☐Y ☐N	
Cannabis/Marijuana	☐Y ☐N	☐Y ☐N	
Alcohol	☐Y ☐N	☐Y ☐N	
Prescribed	☐Y ☐N	☐Y ☐N	
Nicotine	☐Y ☐N	☐Y ☐N	
Caffeine	☐Y ☐N	☐Y ☐N	
Other	☐Y ☐N	☐Y ☐N	
Has use led to problems (e.g., job loss, relationship conflicts, DUI, etc.)?			☐ Yes ☐ No
If yes, please describe:			

ADDITIONAL INFORMATION (You think therapist should know.)

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