INITIAL VISIT *Date of Initial Visit: _____*

Client's Name: _____ *Age:* _____ *Sex:* _____

Level of Education: _____ *Occupation:* _____

Name of Spouse/Partner *(if applicable):* _____ *Age:* _____ *Sex:* _____

Level of Education: _____ *Occupation:* _____

Relationship with this individual: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Please indicate the areas in your life that you are having difficulty: _____

_____

_____

_____

_____

_____

Previous Treatment:

Psychiatric	***Substance Abuse***	***Treatment Outcome***
☐ None	☐ None	_____
☐ Outpatient Counseling	☐ Outpatient Counseling	_____
☐ Inpatient Treatment	☐ Inpatient Treatment	_____
☐ within last 12 months	☐ within last 12 months	_____
☐ one prior admission	☐ one prior admission	_____
☐ 2 or more prior admissions	☐ 2 or more prior admissions	_____

List any childhood/developmental problems: _____

_____

_____

_____

Family of Origin:

Mother's Name: _____ ***Age:*** _____ ***Occupation:*** _____

Level of Education: _____ *If deceased, date and cause of death:* _____

Relationship with her in childhood: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Relationship with her presently: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Father's Name: _____ ***Age:*** _____ ***Occupation:*** _____

Level of Education: _____ *If deceased, date and cause of death:* _____

Relationship with him in childhood: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Relationship with him presently: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Parent's relationship with each other: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Comments: _____

_____

_____

Sibling's name(s) in order of birth including yourself:	*Age*	*sibling(s) of origin*	*half sibling(s)*	*step sibling(s)*
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

Relationship with your grandparents: ☐ *harsh/troubled* ☐ *warm/close* ☐ *cold/distant* ☐ *neutral*

Comments: _____

_____

Have you experienced loss in any relationship conflict or by death? ☐ *Yes* ☐ *No*

If yes, please give a brief explanation: _____

_____

_____

Is there a history of mental illness in your family of origin? (e.g., depression, anxiety, alcoholism) ☐ *Yes* ☐ *No*

If yes, please give a brief explanation: _____

_____

_____

Ethnic background: ☐ *Caucasian* ☐ *African-American* ☐ *Latino*
☐ *Native American* ☐ *Other* _____

Religious/Spiritual Orientation in Family of Origin: _____

_____

Religious/Spiritual Orientation at present: _____

_____

Other significant personal information: _____

_____

_____

_____

Risk Factors: *Are you having any of the following thoughts?*

Suicidal Thoughts:	☐ *Yes*	☐ *No*
Suicidal Plan:	☐ *Yes*	☐ *No*
History of harm to self or others:	☐ *Yes*	☐ *No*

If yes in any area, please describe: _____

_____

_____

_____

Has anyone close to you ever committed suicide? ☐ *Yes* ☐ *No*

If yes, please explain: _____

_____

Do you or does anyone close to you have a history of violent behavior? ☐ *Yes* ☐ *No*

If yes, please describe: _____

_____

_____

Have you ever been convicted of a criminal offense? ☐ *Yes* ☐ *No*

If yes, please explain: _____

_____

_____

Symptoms *(Mental Status):*

☐ Depressed Mood	☐ Hyperactivity	☐ Paranoia
☐ Decreased Energy	☐ Disruption of Thought Process/Content	☐ Dissociative States
☐ Grief	☐ Obsessions/Compulsions	☐ Oppositionalism
☐ Hopelessness	☐ Elevated Mood	☐ Somatic Complaints
☐ Worthlessness	☐ Irritability	☐ Coexisting Medical Condition
☐ Guilt	☐ Impulsiveness	☐ Emotional/Physical/Sexual Trauma Victim
☐ Anxiousness	☐ Delusions	☐ Emotional/Physical/Sexual Trauma Perpetrator
☐ Panic Attacks	☐ Hallucinations	☐ Other (specify): _____

Substance Use/Abuse:	☐ None	☐ Active Substance Abuse	☐ Early Full Remission
	☐ Early Partial Remission	☐ Sustained Full Remission	☐ Sustained Partial Remission
Substances Used:	☐ Tobacco	☐ Caffeine	☐ Alcohol
	☐ Illegal Substances	☐ Prescription Drugs	☐ Non-prescription drugs

*Describe:*_____

_____

Functioning: *Impairment Level*

	None	Mild	Moderate	Marked	Extreme
Marriage/Relationship/Family	1	2	3	4	5
Job/School/Performance	1	2	3	4	5
☐ Disability/Leave			☐ Job Jeopardy		
Friendships/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Activities of Daily Living (personal hygiene, bathing, etc.)	1	2	3	4	5
Eating Habits	1	2	3	4	5
☐ Weight Loss _____lbs.	☐ Weight Gain _____lbs.		☐ Current Weight _____lbs.		
Sleeping Habits	1	2	3	4	5
☐ Difficulty Falling Asleep	☐ Difficulty Staying Asleep		☐ Early Morning Awakening		
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

(For therapists use only)

Diagnosis:	***Initial Treatment Plan:***
Axis I:_____	_____
Axis II: _____	_____
Axis III: _____	_____
Axis IV: _____	_____
Axis V: _____	Current: _____ Highest in last year: _____ Expected GAF at termination: _____

(Document specific GAF – not range)

91-100	Superior Function	81-90	Minimal Symptoms	71-80	Mild/Transient Symptoms
61-70	Mild Symptoms	51-60	Moderate Symptoms	41-50	Serious Symptoms
31-40	Impaired Reality Testing	21-30	Inability to Function	11-20	Some Danger
01-10	Serious danger of harming self or others				

Therapist's Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Diagnosis reviewed with client: ☐ *Yes* ☐ *No*

Signature: _____ ***Date:*** _____

Stacy L Perkins, LCPC
Licensed Clinical Professional Counselor