RUSH CREEK COUNSELING CENTER

Rush Creek Counseling Center
2350 SW Green Oaks Blvd.
Arlington, TX 76017
Phone: 817-704-6991 Fax: 817-701-0379

Please answer the following questions to the best of your ability. If you need additional space for answers, then please use the back of this form. If there are any questions that you prefer to discuss in person, then please feel free to leave them blank.

SOCIAL HISTORY

CLIENT INFORMATION:

Name: _____ Date: _____
Address: _____ City: _____ Zip: _____
E-Mail Address: _____
Home Phone: _____ May we leave a message here: ❑ Yes ❑ No
Cell Phone: _____ May we leave a message here: ❑ Yes ❑ No
Work Phone: _____ May we leave a message here: ❑ Yes ❑ No
Birthdate: _____ Age: _____ Sex: ❑ Male ❑ Female
Education Level: _____
Occupation: _____
Referred to this office by: _____

FAMILY HISTORY:

What kind of relationship do/did you have with your father? *(circle one)*
Excellent Good Fair Poor Nonexistent
What kind of relationship do/did you have with your mother? *(circle one)*
Excellent Good Fair Poor Nonexistent
Did anyone else have a key role in your upbringing? ❑ Yes ❑ No
If yes, then who and why? _____
_____
How many children are in your family of origin? _____
Where are you in birth order *(circle one)* 1st 2nd 3rd 4th 5th 6th Other_____
Any step-brothers or sisters?_____ Any half-brothers or sisters?_____
Please use three or four words to describe the following: (i.e., kind, angry, etc.)
Your female parent: _____
Your male parent: _____
Your family of origin: _____

CURRENT LIFE:

Marital Status: *(circle one)* Single Engaged Married Separated Divorced Widowed
If married, at what age were you married? _____ Your spouse? _____
If divorced, how many times: (circle one) 1 2 3 4 5 6 7
If widowed, at what age? _____ How many years? _____

How many children do you have? _____ How many are living with you now? _____
List names and ages: _____
_____
Who else lives with you other than spouse and children? _____
_____
Please use three or four words to describe the following: (i.e., loving, distant, etc.)
The main person in your life: _____
Your current family: _____

MENTAL / EMOTIONAL HEALTH HISTORY

FAMILY HISTORY:

Are there or have there been any of the following problems in your family? *(check any)*

_____ Substance abuse If so, what? _____

_____ Suicide	_____ Suicide attempts	_____ Trauma / PTSD
_____ Violence	_____ Sexual Abuse	_____ ADHD
_____ Depression or Anger	_____ Anxiety or panic	_____ Cutting / Self-Harm
_____ Bipolar Disorder	_____ "Nervous breakdown"	_____ Obsessive Compulsive Disorder
_____ Psychiatric Hospitalization	_____ Sexual Addiction	_____ Eating Disorder

PERSONAL HISTORY:

Have you personally experienced any of the following problems: *(check any)*

_____ Substance abuse If so, what? _____

_____ Suicide	_____ Suicide attempts	_____ Trauma / PTSD
_____ Violence	_____ Sexual Abuse	_____ ADHD
_____ Depression or Anger	_____ Anxiety or panic	_____ Cutting / Self-Harm
_____ Bipolar Disorder	_____ "Nervous breakdown"	_____ Obsessive Compulsive Disorder
_____ Psychiatric Hospitalization	_____ Sexual Addiction	_____ Eating Disorder

Have you sought counseling before? ❑ Yes ❑ No
What kind? *(circle one)* Pastoral / professional / both
Have you ever attended a support or therapy group? ❑ Yes ❑ No _____
Have you experienced any thoughts of harming yourself? ❑ Yes ❑ No If yes, when? _____
Describe briefly _____
_____
Did you experience any type of abuse as a child? (Physical, sexual, verbal, psychological)
If so, explain _____
_____

CURRENT ISSUES: *(check any)*

_____ Depression or anger	_____ Anxiety or panic	_____ Work issues
_____ Marital problems	_____ Violence or abuse	_____ Parenting
_____ Eating Disorder	_____ Adjustment to an event or situation	
_____ Substance abuse	If so, what? _____	

Please give a brief description about why you are coming to therapy: _____
_____
_____

Please give a brief description about how you think the situation developed: _____
_____
_____

Please state what you hope therapy will do for you and your situation: _____
_____
_____

YOUR OBSERVATIONS: *(answer briefly)*

What was your childhood like? _____
_____

What is your current life like? _____
_____

What is your understanding of your problem? _____
_____

How have you tried to solve it? _____
_____

Are there any other observations that you feel might be important to note in your current life situation? ___
_____
_____

PHYSICAL HISTORY

Please rate your health: (circle one) Excellent Good Average Poor

Current Medications (List any prescription medications you are currently taking . Use back if necessary)					
Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Dosage	Has it been helpful?
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
Describe any side effects that you find troublesome from any of the medications you are currently taking.					
What other psychiatric medications have you taken in the past?					

Date of last physical exam: _____
Please list the name, address, and phone number of your primary care physician: _____
_____

List all important present or past illnesses, injuries, or handicaps: _____

_____

Have you ever had a head injury or been hit in the head? ❑ Yes ❑ No
Did you lose consciousness? ❑ Yes ❑ No
List any current medical problems not included above: _____

_____

SPIRITUAL HISTORY

Were you raised in church? ❑ Yes ❑ No If yes, then what kind? _____
Do you currently believe in God? ❑ Yes ❑ No If not, why? _____

_____

If yes, then list denominational preference: _____
Are you a church member? ❑ Yes ❑ No Name of Church: _____
Church attendance per month: (circle one) 0 1 2 3 4 5 6 7 8 9 10+

The above information is correct to the best of my knowledge. I understand that a written case record containing personal data, session notes, test results, and necessary psychological reports will be kept on each client. This information is privileged and will be held in strict professional confidence except in cases when the client or others are in personal danger and/or laws of agencies or civil authorities are at issue.

_____ _____

Date Signature of Client