



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?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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