Dan Hicks, LPC **www.lastingimpactcounseling.com**

Lasting Impact Counseling, LLC

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Client Name: _____ DOB: _____ Sex: _____ Date Completed: _____

Name of person completing this form and relationship to client: _____

Reason for seeking counseling:

dwd

Problems and Symptoms	**Past**	**Present**	**Not Applicable**	**Explanation**
Change of Appetite	☐	☐	☐	_____
Bingeing/purging food	☐	☑	☐	_____
Weight loss/gain	☐	☐	☐	_____
Insomnia/hypersomia	☐	☐	☐	_____
Withdrawn	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Mood Swings	☐	☐	☐	_____
Anxiety	☐	☐	☐	_____
Obsessive Thoughts	☐	☐	☐	_____
Compulsive Behaviors	☐	☐	☐	_____
Anger Management	☐	☐	☐	_____
Cruelty to Animals	☑	☑	☐	_____
Poor Memory	☑	☐	☐	_____
Processing Difficulty	☐	☐	☑	_____
Fire setting	☐	☐	☑	_____
Bladder Control	☐	☐	☑	_____
Bowel Control	☐	☐	☑	_____
Aggression	☐	☐	☑	_____
Lying	☐	☐	☑	_____
Stealing	☐	☐	☑	_____
Sexual Acting Out	☐	☐	☑	_____
Sexual Dysfunction	☐	☐	☑	_____
Nightmares/night terrors	☐	☐	☑	_____
Vivid dreams	☐	☐	☑	_____
Fears	☐	☐	☑	_____
Unexplained physical complaints	☐	☐	☑	_____
Abuse/neglect	☐	☐	☑	_____
Grief/loss	☐	☐	☑	_____

Stress	☐	☐	☐	_____
Flash Backs	☐	☐	☐	_____
Financial	☐	☐	☐	_____
Addictive Behavior	☐	☐	☐	_____
Impulsivity	☐	☐	☐	_____
Hyperactivity	☐	☐	☐	_____
Lethargic	☐	☐	☐	_____
Poor Concentration	☐	☐	☐	_____
Short Attention Span	☐	☐	☐	_____
Poor Family Relations	☐	☐	☐	_____
Poor Relations in the Workplace	☐	☐	☐	_____
Poor Relations with Peers	☐	☐	☐	_____
Hallucinations/delusions	☐	☐	☐	_____
Difficulty with Authority	☐	☐	☐	_____
Spiritual Issues	☐	☐	☐	_____
Feeling inadequate/Low self worth	☐	☐	☐	_____
Other	_____			

Significant Relationships: ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other ☐ Single

If married/divorced how many times? _____ How long married/divorced? _____

Name children and ages: _____

On a scale of 1-10, 10 being very satisfied, rate level of satisfaction with current relationship: _____

Addiction/Substance Use History:

Substance	Yes	No	Substance	Yes	No	Substance	Yes	No
Alcohol	☐	☐	Pain Pills	☐	☐	Marijuana	☐	☐
Tranquilizers	☐	☐	Stimulants	☐	☐	Inhalants	☐	☐
Sleeping Pills	☐	☐	Narcotics	☐	☐	Food	☐	☐
Hallucinogens	☐	☐	Heroin/Meth	☐	☐	Sex	☐	☐
Gambling	☐	☐	Pornography	☐	☐	Other	☐	☐

Drug of preference: _____ How long used? _____ Last used? _____

Treatment program: _____ When? _____

How long? _____

How long clean/sober? _____

Education:

Highest grade completed: _____ Graduated/degree: _____

Any difficulty learning to Read: _____ Write: _____ Math: _____

Did you ever repeat a grade? Yes/No For what reason: _____

Favorite subject: _____ Most accomplished subject: _____

I learn best by: seeing it done____ reading about it____ hearing about it____

Occupation:

Current occupation/vocation: _____ How long: _____

On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? _____

Please describe any difficulties you are having concerning your occupation: _____

_____

_____

Family History (Please list those family members with a <u>history of mental illness, learning disabilities, mental retardation or addictions</u>) (If you need more space use back of page)

Children: _____

_____

Parents: _____

_____

Siblings: _____

_____

_____

Maternal Grandparents: _____

_____

Paternal Grandparents: _____

_____

Maternal Aunts and Uncles: _____

_____

Paternal Aunts and Uncles: _____

_____

Physician:

Are you currently under a physician's care? _____

Names of Physicians/Specialists who are treating you: _____

_____

Nutrition:

How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)_____

How much tobacco do you smoke/chew daily? _____

How many Alcoholic drinks do you consume: 1-3 Daily ☐ 1-3 Weekly ☐ 1-3 Monthly ☐ None ☐

Please describe any difficulties you are having with health, nutrition, body image: _____

_____

_____

Describe your exercise routine (what you do, how often you do it) _____

_____

Spiritual History:

Do you believe in God? Yes☐ No☐

Do you have a religious affiliation with which you are active? Yes☐ No☐

Do you use any particular religious writings (Bible, Qur'an etc) to find truth for your life? Yes☐ No☐

How does your faith help you to cope with life's problems? _____

_____

_____

Please describe any difficulties you are having concerning your faith _____

_____

Goals for Counseling:

What three things would you like to change by participating in counseling?

1. _____
2. _____
3. _____

How will you know when you have accomplished your goals for counseling? _____

_____

_____

What else do you think is important for your counselor to know about you? _____

_____

_____

Emergency Contact:

Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)

_____

_____

Clients Signature_____Date_____

Primary Caregiver's Signature_____Date_____