SHOREHAVEN
BEHAVIORAL HEALTH, INC.

Client History

Instructions: Please answer these questions for yourself or, if you are a parent bringing a child for therapy, for your child.

Client Name: _____ **Date:** _____

Names of all who reside in household: _____

1. What problem(s) caused you to seek help for yourself or your child?

_____

2. Check if there have been any of these recently:

☐ Anxiety	☐ Changes or problems in eating	☐ Pounding heart	☐ Defiant
☐ Tearfulness, crying	☐ Changes or problems in sleeping	☐ Headaches	☐ Panic
☐ Nervousness	☐ Stomach aches	☐ Irritable	☐ Lying
☐ Depression	☐ Difficulty concentrating	☐ Bedwetting	☐ Sadness
☐ Truancy	☐ Lost interest in activities	☐ Impulsive	☐ Running away
☐ Dizziness	☐ Fatigue, tiredness	☐ Nightmares	☐ Easily distracted
☐ Restless, fidgety	☐ Change in friends	☐ Stealing	☐ Tantrums
☐ Arguing with adults	☐ Excessive worrying	☐ Disruptive in school	☐ Gambling
☐ Chronic pain	☐ Drinking, drug abuse	☐ Withdrawal	☐ Sexual difficulties

☐ Other: _____

☐ Fears (check): ☐ Dying ☐ Going crazy ☐ Darkness ☐ Animals ☐ Other: _____

3. Have there been any recent illnesses or deaths among your family or close friends? ☐ Yes ☐ No

4. Have there been any recent crises or major changes? ☐ Yes ☐ No

5. Has there been any emotional, physical, or sexual abuse? ☐ Yes ☐ No

6. Have you or anyone in your family had any hospitalizations for emotional problems? ☐ Yes ☐ No

If so, when and where: _____

7. Have you or your child ever intentionally hurt him/herself or made a suicide attempt? ☐ Yes ☐ No

8. Have you or anyone in your family been in counseling or psychotherapy? ☐ Yes ☐ No

If so, when and with whom: _____

9. Have you or your child taken medications for anxiety, depression, sleep, etc.? ☐ Yes ☐ No

If so, list them: _____

10. List any other current medical conditions and disabilities:

_____

11. Are you or your child taking any medications? ☐ Yes ☐ No

If so, list them: _____

12. List your physician(s) name(s):

_____

13. Have you or your child had a medical exam within the past year? ☐ Yes ☐ No

14. Indicate if you or your child have any of these problems:

☐ Allergies	☐ Blood pressure issues	☐ Head injuries	☐ PMS
☐ Anemia	☐ Chronic pain	☐ Headaches	☐ Seizures
☐ Arthritis	☐ Constipation	☐ Heart issues	☐ Sexual difficulties
☐ Asthma	☐ Diabetes	☐ Kidney issues	☐ Sexually transmitted disease
☐ Back problems	☐ Emphysema	☐ Liver issues	☐ Skin problems
☐ Bowel issues	☐ Vision, hearing issues	☐ Neurological problems	☐ Speech, language issues
☐ Cancer	☐ Fatigue	☐ OB/GYN problems	☐ Thyroid problems

15. Please describe the drug and alcohol use of your family. Indicate how often and how much each person uses. If you are the client, answer for your situation. If the child is the client, answer for your child's situation.

Who	Beer/Wine/ Liquor	Nicotine	Marijuana	Crack/ Cocaine	Inhalants/ Huffing	Speed/Ecstasy/ Amphetamines	Opiates/Pain Meds/ Oxy/Vicodin/Downers	LSD/OTC/ Other
Self/Child								
Mother								
Father								
Partner/Spouse								

16. Are you concerned about your own or your child's drug or alcohol use? ☐ Yes ☐ No

17. Do you or your child get angry when others criticize the use of drugs or alcohol? ☐ Yes ☐ No

18. Are you concerned about the drug or alcohol use of someone else in your family? ☐ Yes ☐ No

19. Did you or your child grow up in a home at a time when a parent abused drugs or alcohol? ☐ Yes ☐ No

20. Have you or your child ever been arrested (including OWI/DUI)? ☐ Yes ☐ No

21. Have you been involved with Protective Services? ☐ Yes ☐ No

22. Please list any other legal problems:

_____

23. Are you or your child currently enrolled in school? ☐ Yes ☐ No

24. Please list the highest grade level completed: _____

25. If applicable, describe the child's usual performance in school and any relevant changes:

_____

26. What strengths do you or your child have which will help to resolve these problems?

_____

27. What family and community supports and resources are available to you and/or your child to help?

_____

28. Usually, it is helpful in therapy to know about any lifestyle or family values, including religious values. Please tell us about them:

_____

29. Please name any people or organizations that provide help and support to your family:

_____