EDEN COUNSELING, LLC
(248) 602-0322

NAME: _____
DATE OF BIRTH: _____

PERSONAL HISTORY
(Confidential Information)

ADDRESS: _____
Street City State Zip

TELEPHONE: _____/_____ OKAY TO CALL? Yes / No
Home Cell

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

EMERGENCY TELEPHONE: _____/_____
Home Cell

Why have you decided to enter treatment now? _____

_____

What are your goals for treatment? _____

_____

What is the source of distress in your life? _____

_____

What are your main strengths and abilities? _____

_____

What are your hobbies and special interests? _____

_____

What are your weaknesses? _____

_____

Do you spend leisure time (check all that apply): ___ Alone ___ with Family ___ with Friends/Peers

At times do you isolate yourself from others? Yes / No

EDUCATION

Highest grade completed: _____ Are you currently in school? Yes / No

If so, where? _____ Major: _____

Are you satisfied with your current level of education? Yes / No Please explain: _____

_____

EMPLOYMENT

Are you employed: _____ Full-Time _____ Part-Time _____ Unemployed _____ Retired

Employer: _____

Are you satisfied with your current position? Yes / No Please explain: _____

_____

Are you experiencing any financial difficulties? Yes / No Please explain: _____

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RESIDENTIAL SITUATION

Do you live with: _____ Parents _____Significant Other _____ Spouse _____ Alone _____ Other: _____

SOCIAL INFORMATION

Religion: ___ Catholic ___ Protestant ___ Jewish ___ Hindu ___ Muslim ___ Other: _____

Were you raised in a home that practiced the above religion? Yes / No

How important are your religious, spiritual, or faith-based beliefs? _____

MILITARY SERVICE

Have you ever served in the armed forces? Yes / No If so, which branch? _____

Do you have combat experience? Yes / No

LEGAL HISTORY

Have you ever been arrested? Yes / No If so, please explain: _____

Are you currently facing any charges? Yes / No If so, please explain: _____

Are you currently on probation or parole? Yes / No If so, what court and for what reason? _____

_____

FAMILY HISTORY

MARITAL STATUS: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

IF MARRIED: 1st Marriage _____

Age Date # of Children If divorced, provide date

2nd Marriage _____

Age Date # of Children If divorced, provide date

How would you describe your relationship with your significant other? _____

_____

What difficulties have you experienced in your present or past relationships? _____

_____

Have you ever experienced any violence in your relationships (sexual, physical, verbal, or emotional)? Yes / No
If so, please describe: _____

_____

_____

_____

_____

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FAMILY MEMBER	NAME	AGE	EDUCATIONAL LEVEL	DOES THIS PERSON LIVE WITH YOU?
Spouse/ Significant Other				
Children				
Mother				
Father				
Siblings/Others				

BIOLOGICAL PARENTS WERE: _____ Married _____ Unmarried _____ Separated _____ Divorced _____ Unknown

If parents were divorced, how old were you? _____ Describe how the divorce affected you: _____
_____

How would you describe your relationship with your extended family? _____
_____

If adopted, when were you told? _____

Please indicate (circle) if there is a family history with any of the following:

Substance Abuse Yes / No If yes, who?_____
Mental Illness Yes / No If yes, who?_____
Depression Yes / No If yes, who?_____
Anxiety Yes / No If yes, who?_____
Suicide Yes / No If yes, who?_____
Developmental Disability Yes / No If yes, who?_____
Autism Yes / No If yes, who?_____
ADHD Yes / No If yes, who?_____

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PHYSICAL/MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

TELEPHONE/FAX: _____

Last visit to your physician: _____ Reason for last visit: _____

Describe your current general health: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

Are you in any physical pain at this time? Yes / No If yes, please explain: _____
_____

Have you gained or lost weight in the last 30-60 days? Yes / No If yes, how much and why?_____
_____

Do you have any diet or nutritional concerns? Yes / No If yes, please explain: _____
_____

Have you ever binged (excessive or uncontrolled indulgence in food) or purged (self-induced vomiting, use of laxatives)? Yes / No
If yes, please indicate duration and frequency: _____

Do you have any illnesses or medical problems? Yes / No
If yes, please explain: _____
_____

Medical/surgical hospitalization history: _____
_____

CURRENT PRESCRIPTION MEDICATION, OVER-THE- COUNTER MEDICATIONS, HERBAL, AND NATURAL REMEDIES	DOSAGE	FREQUENCY	REASON FOR USE	PHYSICIAN

Are you allergic to any medication(s)? Yes / No If so, which one(s)? _____

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PLEASE CHECK SYMPTOMS THAT APPLY TO YOU

CONSTITUTIONAL SYMPTOMS

___Recent weight change
___Fever
___Fatigue

EARS/NOSE/MOUTH/THROAT

___Nose Bleeds
___Bleeding gums
___Swollen glands in neck

EYES

___Eye disease/injury
___Blurred or double vision
___Glaucoma

CARDIOVASCULAR

___ Chest pain or angina pectoris
___ Palpitations
___ Shortness of breath walking/lying flat

RESPIRATORY

___Chronic or frequent coughs
___Spitting up blood
___Asthma or wheezing

GASTROINTESTINAL

___Loss of appetite
___Nausea or vomiting
___ Painful bowel movements or constipation
___ Frequent diarrhea
___ Rectal bleeding or blood in stool
___Peptic ulcer

GENIOURINARY

___Frequent urination
___Blood in urine
___Kidney stones
___Incontinence or dribbling

MUSCULOSKELETAL

___Joint Pain
___Difficulty in walking
___Muscle pain or cramps

INTEGUMENTARY (SKIN)

___Varicose Veins
___Rash or itching
___Change in skin color

NEUROLOGICAL

___ Stroke
___ Convulsions or seizures
___ Frequent or recurring headaches

ALLERGIES/IMMUNE

___Itchy or runny nose
___Itchy or running eyes
___Food intolerances

ENDOCRINE

___Thyroid disease
___Glandular or hormone problem
___Diabetes
___Change in hat or glove size
___Heat or cold intolerance

HEMATOLOGIC/LYMPHATIC

___ Slow to heal after cuts
___Phlebitis
___ Past transfusion
___Bleeding or bruising tendency
___Anemia

TRANSMITTED DISEASE

___Hepatitis
___HIV
___Syphilis

Patient is responsible to follow up with their Primary Care Physician or Specialist for any above positives on this page.

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SUBSTANCE USE AND HISTORY

SUBSTANCE	AGE OF ONSET	AGE AT REGULAR USE	AGE OF LAST USE	AMOUNT USED IN LAST 48 HOURS	AMOUNT USED IN LAST 30 DAYS	HAS AMOUNT USED INCREASED?
Alcohol						
Benzodiazepines (Xanax, Klonopin, Ativan, etc.)						
Cocaine/Crack						
Methamphetamines						
Opiates (Vicodin, Oxycontin, Heroin, etc.)						
Marijuana						
Hallucinogens (PCP, LSD, Mescaline, etc.)						
Inhalants						
Caffeine						
Energy Drinks						
Nicotine						
Other						

BEHAVIORAL HEALTH

Are you now or have you ever thought of or attempted to hurt yourself? Yes / No If so, please explain: _____

_____

Are you now or have you ever thought of or attempted to hurt someone else? Yes / No If so, please explain: _____

_____

Do you have access to firearms or other weapons? Yes / No If so, please describe: _____

MENTAL HEALTH TREATMENT

TREATMENT PROVIDER	PERIOD OF TIME	INPATIENT OR OUTPATIENT	REASON	WHY DID YOU STOP?

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PAST PSYCHIATRIC MEDICATION USED	DOSAGE	DATES OF USE	RESPONSE TO MEDICATION

Have you ever attended a support group (AA, NA, Grief, etc.)? Yes / No If yes, what group and for how long? _____
_____

Have you ever experienced any: ___ Physical Abuse ___ Sexual Abuse ___ Emotional Abuse ___ Abandonment/Neglect
If yes, by whom? _____
Length/duration of abuse: _____ Age of abuse: _____

IAPT PHOBIA SCALES								
Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.								
0	1	2	3	4	5	6	7	8
Would not avoid it		Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it
1.	Social situations due to fear of being embarrassed or making a fool of myself.							
2.	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness).							
3.	Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).							

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GAD-7	Over the past 2 weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervous, anxious or on edge.	**0**	**1**	**2**	**3**
2.	Not able to stop or control worrying.	**0**	**1**	**2**	**3**
3.	Worrying too much about different things.	**0**	**1**	**2**	**3**
4.	Trouble relaxing.	**0**	**1**	**2**	**3**
5.	Being so restless that it is hard to sit still.	**0**	**1**	**2**	**3**
6.	Becoming easily annoyed or irritable.	**0**	**1**	**2**	**3**
7.	Feeling afraid as if something awful might happen.	**0**	**1**	**2**	**3**
For office use only	***GAD-7 total score =***				

PHQ-9	Over the last 2 weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things.	**0**	**1**	**2**	**3**
2.	Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3.	Trouble falling or staying asleep, or sleeping too much.	**0**	**1**	**2**	**3**
4.	Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5.	Poor appetite or overeating.	**0**	**1**	**2**	**3**
6.	Feeling bad about yourself – or that you are a failure or have let yourself or family down.	**0**	**1**	**2**	**3**
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	**0**	**1**	**2**	**3**
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9.	Thoughts that you would be better off dead or of hurting yourself in some way.	**0**	**1**	**2**	**3**
For office use only	***PHQ-9 total score =***				

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Please sign this document below. You will review with your therapist during your next visit.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Signature with Credentials Date