Turner of Life Counseling

Where Lives Matter

Turner of Life Counseling
10730 Potranco Road, Ste 122/192
San Antonio, TX 78251
Phone (830) 542-8445
www.turnoflife.com

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:____

(Circle One)
Home Phone: ___________________________May we leave a message here: **Yes** or **No**
Cell Phone: ____________________________ May we leave a message here: **Yes** or **No**
Work Phone: ___________________________ May we leave a message here: **Yes** or **No**
Birthdate: __________________________ Age: _____________ Sex: **Male** or **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** or **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   _____ Depression or Anger
_____ ADHD   _____ Anxiety or panic   _____ Cutting / Self-Harm
_____ Bipolar Disorder   _____ "Nervous breakdown"   _____Eating Disorder
_____ Sexual Addiction   _____Obsessive Compulsive Disorder
_____ Psychiatric Hospitalization

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   _____ Depression or Anger
_____ ADHD   _____ Anxiety or panic   _____ Cutting / Self-Harm
_____ Bipolar Disorder   _____ "Nervous breakdown"   _____Eating Disorder
_____ Sexual Addiction   _____Obsessive Compulsive Disorder
_____ Psychiatric Hospitalization

Have you sought counseling before? **(Circle One)** **Yes** or **No**
What kind? **(Circle One)** Pastoral / Professional / Both
Have you ever attended a support or therapy group? **(Circle One)** **Yes** or **No**
Have you experienced any thoughts of harming yourself? **(Circle One)** **Yes** or **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/AREA OF DIFFICULTY: (check all that apply)

_____ Depression   _____ Panic attacks   _____ Work issues
_____ Marital problems   _____ Physical abuse   _____ Parenting
_____ Eating Disorder   _____Assertiveness   _____Nervousness
_____Education   _____Health Problems   _____Career choices
_____Stomach problems   _____ Self-concept   _____ Marriage
_____Sexual problems   _____Religion   _____Nightmares

_____Loneliness
_____Energy
_____Suicidal thoughts
_____Sleep difficulties
_____Parents
_____Relaxation
_____Shyness
_____Dating
_____Headaches
_____Anger
_____Appetite
_____Fears
_____Confusion
_____Relationships
_____Grief/loss
_____Body Image
_____Guilt
_____Lack of self-confidence

_____Concentration
_____Ulcers
_____Nervousness
_____Decision making
_____Sexual orientation
_____Infidelity
_____Inferiority
_____Memory
_____Tiredness
_____Impulsivity
_____Anxiety
_____Worry
_____Premarital
_____Self-control
_____In-laws
_____Pornography
_____Eating disorder
_____Feelings of rejection

_____Separation
_____My thoughts
_____Infertility
_____Children
_____Divorce
_____ Sexual abuse
_____Friends
_____Drug use
_____Distractibility
_____Finances
_____Unhappiness
_____Work
_____Food
_____Sadness
_____My past
_____Alcohol use
_____Temper
_____Other:

Specify:____

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 Medication (List any prescriptions medication you are currently taking. Use back if necessary)						
Name of Drug	**Reason for Usage**	**Date Started**	**Frequency Taken**	**Dosage**	**Has it been Helpful? (Circle One)**	
					Yes	No
					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 your 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? **(Circle One)** **Yes** or **No**

Did you lose consciousness? **(Circle One)** **Yes** or **No**

List any current medical problems not included above:___________________________________

____

SPIRITUAL HISTORY

Were you raised in church? **(Circle One)** **Yes** or **No** If yes, then what kind?______________

Do you currently believe in God? **(Circle One)** **Yes** or **No**

If yes, then list denominational preference: ____

Are you a church member? **(Circle One)** **Yes** or **No**

Name of Church: ______________________________________

Church attendance per month: (circle one) 0 1 2 3 4 5 6 7 8 9 10+

Emergency Contact Name:____

May we leave a message with your emergency contact: **Yes** or **No**

Relationship to you:____

Phone:____

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