HOUGH COUNSELING AND ASSESSMENTS, PLLC
PATIENT INFORMATION PACKET

Therapist: _____ Patient's Name_____ Date: _____

PERSONAL HISTORY INFORMATION

What made you to decide to seek help now? _____

What would you like to achieve in counseling? _____

SYMPTOMS

Please circle all the items that you are experiencing.

ANXIETY	**PANIC ATTACKS**	**OBSESSIVE COMPULSIVE BEHAVIOR**
DEPRESSION	**CRYING SPELLS**	**HOPELESSNESS**
RELATIONSHIP PROBLEMS	**RELATIONSHIP BREAKUP**	**ANGER**
LONELINESS	**EMPTINESS**	**LOSS OF APPETITE**
SLEEP DISTURBANCE	**NIGHTMARES**	**HEARING VOICES**
FEELING CONTROLLED	**FEELING TALKED ABOUT**	**VISUAL HALLUCINATIONS**
UNUSUAL THOUGHTS	**INCREASED ALCOHOL USE**	**INCREASED DRUG USE**
BLACKOUT/MEMORY LOSS	**WITHDRAWAL SYMPTOM**	**YELLING OR BREAKING THINS**
FOOD BINGING	**PURGING**	**ENDANGERING OTHERS**
HITTING	**ENDANGERING SELF**	**SEXUAL BEHAVIOR**
GAMBLING	**INCREASED SPENDING**	**MOOD SWINGS**
CANNOT CONCENTRATE	**CONFUSION**	**JOB STRESS**
RACING THOUGHTS	**FEAR OF DYING**	**GUILT/SHAME**
DECREASE ACTIVITY	**DECREASE SELFCARE**	**SCHOOL PROBLEMS**
FINANCIAL WORRIES	**SEXUAL PROBLEMS**	

Comments/Other Symptoms: _____

How long have you been experiencing these symptoms? _____

Do you have any thoughts now or recently of harming yourself? _____

Have you ever attempted to commit suicide or seriously harm yourself? ☐Yes ☐No When? _____

Please explain (how/why): _____

Has anyone in your family attempted or committed suicide? ☐Yes ☐No Who? _____

Please explain:_____

Have you ever attempted to kill or seriously harm someone else? ☐Yes ☐No Who? _____

Please explain: _____

Please mark "N/A" for sections that do not apply

Have you ever experienced any of the following? Physical Abuse ☐Yes ☐No Sexual Abuse ☐Yes ☐No

Emotional Abuse ☐Yes ☐No Verbal Abuse ☐Yes ☐No

Please explain:_____

Have you ever received treatment for the abuse: ☐Yes ☐No If yes, when? _____

Was it helpful? _____

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PREVIOUS TREATMENT

List all the previous experience you have had with counseling/mental health:

Dates:_____ Reason:_____

Outcome:_____

Was your experience helpful?_____

List all mental health/psychiatric hospital or residential treatment centers you have been admitted to:

Dates:_____ Reason:_____

Location:_____Outcome:_____

_____

Was your experience helpful? _____

Have you recently, or in the past, ever been prescribed medications to treat a psychiatric condition: ☐Yes ☐No

Have any of those medications helped? ☐Yes ☐No Please Explain: _____

Is there a history of psychiatric treatment or hospitalizations in your family? ☐Yes ☐No

Please explain:_____

_____

Are you involved in a support groups? ☐Yes ☐No. Which ones: _____

PHYSICAL HEALTH

Please list all medical conditions you have had or currently have and the approximate age of onset:

Condition: _____ Age First Occurred: _____ Currently Treated ☐Y ☐N

Are you allergic to any medication? ☐Yes ☐No Please List: _____

Do you have any other allergies? ☐Yes ☐No If Yes, (Explain): _____

Do you currently take any medications? ☐ Yes ☐No

NAME OF MEDICATION	DOSAGE TAKING	DID DOCTOR PRESCRIBE IT?

Primary Care Physician's Name: _____

Address:_____ City:_____

State:_____ Zip Code: _____ Phone:_____

Date of your las physical: _____ Results: _____

Preferred Hospital (in case of emergency): _____

PERSONAL HEALTH INFORMATION

Have you experienced any significant weight changes? ☐Yes ☐No Explain: _____

_____

Do you exercise regularly? ☐Yes ☐No How many days per week: _____

What kind of exercise do you do? _____

How would you rate your diet? ☐Healthy ☐Unhealthy ☐Mixed. Are you concerned about your diet? ☐Yes ☐No.

Please explain: _____

Do you have trouble sleeping? ☐Yes ☐No Explain: _____

FAMILY INFORMATION	FULL NAME	AGE	LIVING WITH YOU	DECEASED
Father				
Stepfather				
Mother				
Stepmother				
Siblings				
Spouse/Partner				
Roommate/other				

Current Relationship Status: _____ Number of Marriages: _____

Age Married/Together Years Married/Together Reason Ended: _____

_____

_____

Are you currently living with a partner: ☐Yes ☐No?

Assessment of current relationship: ☐Good ☐Fair ☐Poor

Parents marital status: _____Number of Parents Marriages: _____

If parents are divorced, your age at time of divorce: _____

Relationship to parents during childhood: ☐Good ☐ Fair ☐Poor

Who were you raised by? _____ Were you adopted? ☐Yes ☐No

Which family members are you close to now? _____

INTERESTS/ACTIVITIES

What do you enjoy doing in your free time? _____

Have you recently lost interest in activities that you normally enjoyed? ☐Yes ☐No

Please explain:_____

SPIRITUALITY/BELIEFS

Do you practice spirituality? _____

Do you have certain beliefs about spirituality? _____

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ALCOHOL AND DRUG USAGE

Please complete even if you feel your usage is not a problem

About how often do you drink alcohol? _____

On the days that you drink, about how much do you consume? _____

Have you ever experienced blackouts when drinking? ☐Yes ☐No

If you used to drink, when did you stop?_____ Why?:_____

Please list other drugs used regularly or recreationally (including caffeine, cigarettes, marijuana, illegal drugs, or misused prescription medications):

NAME OF DRUG	AMOUNT USED	AGE FIRST BEGAN	LAST USED

Have you ever overdosed? ☐Yes ☐No With what substance? _____

Explain situation: _____

Has drinking or drug use ever caused you a problem in any of the following areas?

☐Family ☐Legal ☐Social ☐Behavior ☐Employment ☐Emotional ☐Financial ☐Medical

Has a friend, loved one, or employer ever told you that you have a drug or alcohol problem? ☐Yes ☐No

Has a friend, loved one, or employer ever commented on your usage? ☐Yes ☐No

Have any family members had a drug or alcohol problem? ☐Yes ☐No Who? _____

LEGAL HISTORY

Have you ever been arrested? ☐Yes ☐No Are you currently on probation? ☐Yes ☐No

Are you currently on parole? ☐Yes ☐No Ending probation/parole date: _____

Are you currently involved in any lawsuits? ☐Yes ☐No Explain: _____

Do you have any upcoming court dates? ☐Yes ☐No When/For which court? _____

Please list all current and previous arrests/charges:

Arrest Date: _____ Charge: _____ Convicted? ☐Yes ☐No

Sentence: _____

FINANCIAL

Do you currently have any financial problems? ☐Yes ☐No

Please explain:_____

EDUCATION

Highest level of education completed: _____

Where did you attend last? _____

EMPLOYMENT

Occupation: _____ Employer: _____ Years Employed: _____

Reason for Leaving: _____

Have you ever been fired from a job? ☐Yes ☐No How many times? _____

Reasons:_____

Do you have any problems at your current job? ☐Yes ☐No Please explain: _____

_____

_____

Are you satisfied with your level of employment? ☐Yes ☐No Please explain: _____

_____

Employment goals:_____

MILITARY SERVICE

Have you ever served in the military? ☐Yes ☐No Branch: _____ Years served: _____

Type of discharge (explain if dishonorable): _____

_____

Did you have any combat experience? ☐Yes ☐No Location: _____

Are you troubled now by your military experience? ☐Yes ☐No If so, explain: _____

_____

_____

Gender: ☐ Male ☐Female ☐Other

Ethnicity: ☐Caucasian ☐African American/Black ☐American Indian ☐Hispanic ☐Asian ☐Other _____

_____

Patient's Signature Date

_____

Therapist's Signature/Credentials Date