KIMBERLY DUDLEY COUNSELING, LLC

KIMBERLY DUDLEY, MA, NCC

Confidential Client History Form:

Client Name: ____ Date: ____________

Medication Allergies:

____

____

Other Allergies:

____

____

Current medications (including over-the-counter and homeopathic supplements):

____

____

Do you follow your medication regime? ☐ Yes ☐ No

Physician name and/or clinic name:

____

Consent to consult with physician? ☐ Yes ☐ No Phone:________________________

Physician diagnosed medical problems:

____

____

Past surgeries:

____

____

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REASONS FOR SEEKING SERVICES

Please describe your concerns and goals:

____

____

____

Symptoms/Issues:

(Please enter 1-3 for degree of difficulty 1=Minor, 2=Moderate, 3=Severe)

	Sad/Depressed		Anxiousness		Memory Problems
	Decreased energy		Excessive energy		Lack of Energy
	Hopelessness		Panic attacks		Acting Violently
	Worthlessness		Obsessions/ Compulsions		Sexual Problems
	Guilt/Shame		Loss and Grief		Paranoia
	Loss and Grief		Difficulty concentrating		Pornography Issues
	Suicidal thoughts		Self-harm		Perfectionism
	Abuse Victim/ Perpetrator		Trauma History		Conflict in Relationships
	Substance Use		Financial Difficulties		Parenting Concerns
	Abortion		Mood Swings		Irritability
	Anger		Sleep Issues		Racing Thoughts
	Feel like you're not in your body		Blackouts		Over Eating
	Eating Disorder		Weight Concerns		Gambling
	Other:				

Prior Treatment or Assessment

Prior Mental Health Treatment:

☐ Outpatient, details:

____

____

☐ Inpatient, details:

____

____

Prior Testing or Evaluation: ☐ Yes ☐ No

Please describe tests administered, results, diagnoses, conclusions, recommendations, etc.: ____

____

Average hours of sleep: __________ Quality of sleep: ______________________________

Family Background

Briefly describe your family of origin (Description of parents, parent's relationship, siblings, home atmosphere, etc.):

____

____

____

History of mental health conditions in the following family members

(please check all that apply):

	Father	Mother	Sibling	Grandparent	Aunt/ Uncle	Other
Substance Abuse						
Alcohol Abuse						
Depression						
Anxiety/Panic						
Bipolar						
Moodiness/Anger						
ADHD						
Developmental Delays						
Learning Disability						
Psychosis						
Seizures						
Suicide						
Dementia						

1. Do you smoke? ______________________

   If yes, is this a concern of yours? Do you understand the implications of using tobacco products?____

2. Do you use alcohol? ________________ If yes, would you describe your use as --

   Minimal _________ Moderate _________ Heavy_________

3. Have you ever been treated or diagnosed with Alcoholism / Alcohol Abuse / Drug Addiction / Drug Abuse? ____

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4. Have you abused prescription medications (your own or someone else's)?

   _______Type?____

Briefly describe your current family situation (Description of family dynamics, concerns, home atmosphere, etc.):

____

____

Marital Status:	Current Relationship Satisfaction:	Family of Origin Satisfaction:
_____ Single, never married	____ Very Satisfied	____ Very Satisfied
____ Engaged	____ Somewhat Satisfied	_____ Somewhat Satisfied
____ Married____ years	____ Satisfied	____ Satisfied
____ Divorced _____ years	____ Somewhat Dissatisfied	____ Somewhat Dissatisfied
____ Separated	____ Very Dissatisfied	____ Very Dissastisfied
____ Divorce in progress	____ Never Been in a Serious Relationship	
____ Widowed	____ Not Currently in a Relationship	
History of Abuse:	____ Emotional ____ Physical	____ Sexual ____ Verbal
Have you ever been forced into a sexual act?	____ Yes ____ No ____ Unknown	
Have you ever been touched inappropriately?	____ Yes ____ No ____ Unknown	
Afraid of partner/anyone	____ Yes ____ No ____ N/A	

Please describe your social support:

☐ Supportive Network
☐ Few Friends
☐ Substance-use based friends
☐ No Friends
☐ Family Supportive
☐ Distant from family of origin
☐ Family Conflict

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Academic Background:

☐ Current School: ______________________________ ☐ Part time ☐ Full Time

Highest Level of Education:

☐ Some HS ☐ Some College ☐ College Graduate

College Degree(s) ____

Do you participate in spiritual activities? ☐ Yes ☐ No

Where: ____________________________________

Do you want spirituality to be a part of treatment? ☐ Yes ☐ No ☐ Unsure

Employment History/Military/Legal Background

Current Employment Status: ____

Current Occupation: ____

Military Service? ☐ Yes ☐ No Branch: ______________________________

Briefly describe active duty/deployment:

____

Legal Concerns: ☐ Yes ☐ No

Briefly describe any concerns: ____

Is it your statement that you have answered all questions and inquiries in a truthful and honorable manner? ☐ Yes ☐ No

____ ___________________

Signature Date

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