Greater Life Counseling Center

11 Lumpkin Street, Suite 100, Lawrenceville, GA 30046

Clinical History Form

General Information:
Name: _____ Date: _____
Age _____ Sex: _____ Ethnicity: _____
Marital Status: _____ Employer: _____ Education: _____

What are the three most important problems that have brought you to our center at this time:
_____
_____

How have you addressed these concerns already? _____
_____
_____

What would you like to accomplish in therapy here? _____
_____

Medical/Clinical Information:
Describe your current health, including but not limited to diet and exercise _____
_____

Please check the symptoms you are currently experiencing:

___ Depression ___ Weight Changes ___ Difficulty Concentrating ___ Use of Drugs/Alcohol
___ Panic Attacks ___ Perfectionism ___ Difficulty Sleeping ___ Grief/Loss
___ Body Aches/Pains ___ Nightmares ___ Anxiety ___ Trauma
___ Loneliness/Isolation ___ Suicidal Thoughts ___ Inferiority Feelings ___ Relationship Problems
___ Rage/Anger ___ Hopelessness ___ Confusion ___ Sexual Concerns
___ Thoughts of harming others

Have you ever been treated for a mental health problem with?
___ Counseling ___Medication ___Hospitalization

List your Health Care Provider(s): _____
Date of Last Physical Exam: _____
Current Medications: _____
_____
List current involvement with other mental health professionals: _____
_____

- **Continue on Reverse –**

Family/Social Information

List parents, siblings, and any other significant members in your household growing up:

Name	Sex	Current Age	Relationship to you

What was it like for you growing up in your family? _____
_____
_____

List current partners, children, and/or others in your household:

Name	Sex	Current Age	Relationship to you

What is it like for you in your current living situation? _____
_____
_____

Do you feel you have adequate social support? Describe your current support system: _____
_____
_____

Please Check the following if appropriate:

	You		**Household Members**	
	Past	*Present*	*Past*	*Present*
Substance Abuse				
Neglect/Physical Abuse/Family Violence				
Sexual Abuse				
Mental Illness				
Chronic Physical Illness				

List your denominational Preference/church affiliation: _____
Active _____ Inactive _____