Mark S. DeBord, LCSW
First West Counseling Center

Date: _____ Case #: _____Name: _____

1. Where were you born? _____Reared? _____
2. I was child number _____in a family of _____children.
3. Number of brothers _____sisters _____.
4. Were you adopted? _____yes _____no.
5. If your mother/ father did not rear you, who did? _____
6. If your parents separated, how old were you? _____
7. If your parents divorced, how old were you? _____
8. Number of times mother divorced _____father _____

9. Mother's occupation_____father's_____

10. Mother's religion_____father's_____

11. How often did you attend as a child? _____

12. Describe the type person your mother/ mother substitute was when you were a child and your relationship. _____

_____

_____

13. Describe the type person your father/ father substitute was when you were a child and your relationship.

_____

_____

14. Was there any abuse? _____yes _____no. If so, briefly describe: _____

_____

15. Describe your relationship with your siblings.

_____

_____

16. Mother's age _____If deceased, when did she die? _____
17. Father's age _____If deceased, when did he die? _____
18. Years of formal education completed (circle #) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 more

Degree(s) earned: _____

19. In what extracurricular activities were you involved? _____

_____

20. If you did not finish High School, why did you stop? _____

21. List any military experience. _____
22. Present marital status: _____never married _____married now for the first time _____remarried _____separated _____divorced and not remarried _____widowed and not remarried Sexual Orientation: _____
23. Age when first married: _____ How many times have you been married? _____
24. List children by name and give ages. _____

_____

25. If you are married or in a relationship now, please describe level of satisfaction and/or list major problems. _____

_____

_____

26. What is your chosen occupation? _____

    What is your present job? _____Years at present job_____

27. List your main school/ work difficulties/ problems: _____

_____

28. List the things you like to do most (hobbies, etc.), the things that give you pleasure.

_____

29. List your main social difficulties. _____

30. Do you have close friends and/or strong family supports? _____ If so, please describe: _____

_____

31. List any legal problems (current)_____

    (past)_____

32. Have you drank any alcohol at all? _____yes _____no If yes, how old were you when you started?_____
    Do you drink any alcohol now? _____yes _____no
    If no, how much of what did you drink and when did you stop? _____

    If yes, how much of what do you drink? _____
    What is the most you will drink in one day? _____
    How often do you drink that much? _____
    Have you ever used street drugs or abused Rx drugs? _____yes _____no If yes, how old were you when you started?_____
    Do you use street drugs now? _____yes _____no
    If no, how much of what did you use and when did you stop? _____

    If yes, how much of what do you use? _____
    Have you ever had any substance abuse treatment? _____yes _____no

    If yes, please list. _____
    Do you or have you had problems with gambling? _____yes _____no
    Please explain. _____

33. List any family members who have had emotional, gambling or substance abuse problems.

    _____

34. List any previous behavioral health services that you have received: _____

_____

35. How important is religious activity/ spirituality to you on a scale of 1-10 with 10 being very important? _____

36. What church are you presently attending? _____ how often? _____

37. List your main personal strengths. _____

    _____

38. List your main personal weaknesses. _____

_____

39. List your main life goals. _____

_____

40. List the things about yourself that you most want to change. _____

_____

41. What do you **MOST** want to accomplish in counseling? _____

41. List: (1) Any current allergies: _____

(2) Any current physical problems or illnesses: _____

(3) Any past physical problems or illnesses: _____

(4) Any surgeries: _____

(5) Primary Care Physician: _____

(6) Current medications: _____

42. Have you ever used tobacco products? _____ yes _____ no. Do you use tobacco products now? _____yes _____no

If yes to either question above, describe (what and how much) _____

Quit date, if applicable: _____

THANK YOU!

_____

Therapist's Signature Date