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Initial Summary

Client Name/s: ______________________________ Date: ________

Chief Complaint: ______________________________

Previous Therapy (circle): Counselor Group Family Therapy Hospitalization

Current Medications:

Drug: ________________ Dose: ________ Reason: ________

________________ ________ ________

________________ ________ ________

Alcohol Use (circle): Daily Every Now and Then Weekends

Drug Use: Drugs of Choice ________________ Frequency ________________

In the past 12 months (circle or fill in):

Death of loved one	Change Employment	Move
Relationship Break Up	Church Transition	Self Harm: cut/burn/etc.
Suicide Attempt	Anorexia / Bulimia	Financial Loss
Miscarriage/Abortion	Panic Attacks	Migraines
Legal Issues	Hospitalization	Pregnancy
Other ____________		

Spiritual Preference: ______________________________

Hobbies/Interests: ______________________________

Current Living Situation (circle): House Apartment Room/Board Other

Recent Medical Care in Past 12 months:

Doctor: ________________ Reason: ________________

________________ ________________

Exercise: (circle): Very Good Good Fair Poor

Nutrition (circle): Very Good Good Fair Poor

Sleep: ________________ Sleep Apnea: Y N Unknown

Short Term Counseling Goal: ______________________________

Long Term Counseling Goal: ______________________________

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