CENTERED
COUNSELING

Adult and Family History Form

Client Name: _____

Date of Birth: _____

Phone Numbers:

Home: _____

Cell: _____

Work: _____

Address: _____

_____

_____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

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Thiensville, Wisconsin 53092

If form completed for your child:

Mother: _____ Primary phone: _____

Mother: _____ Primary phone: _____

Name of School: _____

Current Grade: _____

Briefly describe the problem for which you are seeking help:

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

Have you or your family ever seen a counselor/psychiatrist/social worker in the past?: *yes* *no*

If yes, who did you see, when and for how long? Was this helpful to you or your family, please explain:

MEDICAL HISTORY:

Describe present medical conditions:

Please list all medications you or your child are currently taking and prescribing physician(s):

Use of narcotics or other pain medication? *Yes* *No*
If yes please list:

SOCIAL HISTORY:

Where were you born? _____

Religion (optional): _____

Are your parents living? _____

Marital Status: _____

Name of Spouse: _____

Number of Individuals in household: _____

Name of Individuals living in the household and their relationship to you/your child:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you drink alcohol? *yes* *no*

If yes: ____ times per week and _____ drinks on the days alcohol is consumed

EMPLOYMENT HISTORY (complete for caregivers of children):

Are you currently employed? *yes* *no*

Present Occupation: _____

Place of Employment: _____

How long have you worked at this job? Years: Months:

Longest job held: Years: Months:

Title and/or name of position: _____

Name three other jobs you've been employed in, and length of employment:

1. _____
2. _____
3. _____

Have you ever served in the Military? *yes* *no*

If yes, please give dates and positions in Military:

_____

_____

_____

ADDITIONAL INFORMATION THAT WOULD BE HELPFUL:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Client: _____ Date: _____

Therapist Signature: _____ Date: _____