Owasso Counseling

13720 E. 86th St. N. Ste.170
Owasso, OK 74055

Laura Long, MA, LPC
(918) 698-2281

Adult Client Information

Name: DOB: Age: Gender:

Address:
Street City, State Zip Code

Home #: Cell #: Work #:

Emergency Contact Name: Phone:

Religious Preference: Ethnicity:

Primary Occupation:

Highest Level of Education Completed:

Are you a military veteran? ☐ No ☐ Yes If yes, years of service _____to_____

Please describe in your own words the major reason for seeking my services at this time.

How serious would you say this problem is right now?

NOT AT ALL SERIOUS ☐SLIGHTLY SERIOUS ☐MODERATELY SERIOUS ☐VERY SERIOUS

How likely do you think the problem is to change?

☐NOT AT ALL LIKELY ☐SLIGHTLY LIKELY ☐MODERATELY LIKELY ☐VERY LIKELY

What are your expectations and goals of participating in counseling? _____

If you experienced trauma, abuse, neglect; please describe _____

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Medical History

List all medications and/or drugs taken within the last 6 months, both prescription and non prescription.

Name of medication/drug	Reason Taken	Check if taking now

Do you drink alcohol? ☐ No ☐ Yes if yes, how much?

Has anyone expressed concern for how much you drink? ☐ No ☐ Yes If yes, who?

Do you think another family member drinks too much? ☐ No ☐ Yes If yes, who and please explain.

Have you ever attempted suicide? ☐ No ☐ Yes If yes, give date(s) and details.

Has anyone in your family ever attempted suicide? ☐ No ☐ Yes If yes, give name(s), relationship to you, and details.

Have you ever been inpatient for mental health reasons or substance abuse?_____
If yes, when, where and why were you hospitalized?_____

What diagnoses of mental health issues have you received in the past?

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Have you had previous counseling? _____ If yes, please list with whom, reason and when

_____

_____

_____

Family-of-origin history

Family Member	Living? (Y/N)	Age	Health Good	Fair	Poor	If deceased, cause of death
Father						
Mother						
Brothers						
Sisters						

Check condition and relationship of any blood relative who has or has had any of the conditions listed below	Mother	Father	Paternal grandfather	Paternal grandmother	Paternal aunt/ uncle	Maternal grandfather	Maternal grandmother	Maternal aunt/ uncle	Siblings	Other ____
Alcoholism/Substance Abuse										
Allergies										
Birth Defects										
Cancer										
Colitis										
Depression										
Heart Attack										
High Blood Pressure										
Migraine										
Mental Illness										
Seizure Disorder										
Mental Retardation										
Learning/Attention Problems										
Suicide/Suicide Attempt										
Other (Specify)										

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Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

Date of current marriage: _____ Spouse's name: _____ Spouse's age: _____

Significant nonmarital relationships

Name of person	Person's age when started	Person's age when ended	Your age when started	Your age when ended	Reasons for ending
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column, and those living in your home with an H)

Name	Current age	Sex	School	Grade	Adjustment problems?	P/H
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___

K. Spiritual Life: Do you want to incorporate spiritual or religious beliefs in your treatment? _____

Signature: _____ *Date:* _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.