Marilee Boe, M.A., L.P.C.

Client Information

_____-

Client Name

Please tell me your age, with whom you live, and how you spend your day.

Please describe your primary problem.

What are the symptoms of your problem? How long has this been a problem?

Please scale the severity of your problem from 0-10 (10 = very severe)

Please describe your physical health and any medications your are taking. Do you have any medication allergies?

Have you received counseling services or been hospitalized before? Briefly describe your experience.

Please share any family history regarding moods, anxiety, substance, legal, or behavior problems.

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Client Name

How much alcohol do you consume? Tell me about your history with illicit substances or problems with prescription medication.

Tell me about your education. What were your strengths? What was difficult?

Briefly describe your work history.

Tell me about your sleep history and current sleep patterns.

Describe your involvement in social activities.

What sort of religious traditions did your family observe, if any, when you were a child. Please describe your current spiritual orientation, if any.

Please describe your parents/caretakers when you were a child. How many brothers and sisters did you have? Where do you fall in the sibling order? With whom were you close? With whom were you conflicted?

_____

Client Name

Tell me about your exercise routine.

Tell me about your significant other, if there is one. What are the strengths in your relationship? What areas need work? Are there any problematic patterns with former romantic partners?

Please tell me about any trauma you have experienced in your lifetime. This could include: losses, natural disasters, witnessing traumatic events, physical, emotional, verbal, and or sexual abuse.

Do you now, or have you ever seen or heard sounds or voices that you suspect may not have been real?

Tell me of any past history, or current thoughts of violence:

against yourself:

against others:

Do you have firearms in your home?

What are your goals for therapy?

What would you like to do more of?

_____-

Client Name

What would you like to do less of?

Who can support you in your goals?

Please scale your readiness/willingness to make needed changes from 0-10, where 0 is unwilling and 10 is extremely willing.

Do you have any information you would like to add?

Recommendations:

_____

Print Name Here

_____ _____-

Client Signature Date

_____-

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