IVY COUNSELING GROUP, LLC
NURTURING INTERNAL RESILIENCE & STRENGTH

Personal History

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning to life?

What do you need help with? (Please check all that apply)

□ Marriage/Significant Other
□ Extramarital Relationship
□ Children/Parenting
□ Anxiety
□ ADHD
□ Autism
□ Depression
□ Grief/ Death
□ Psychosis
□ Mood Swings
□ Employment/ School
□ Physical/ Medical
□ PTSD/ Trauma
□ Abuse (please specify):
□ Addiction (please specify):
□ Other (please specify):

Mental Health History

Have you experienced any of the following within the past 90 days? (Please check all that apply)

□ Suicidal Thoughts
□ Panic/Phobia
□ Paranoia/Delusions
□ Depression
□ Self Injury
□ Poor sleep patterns
□ Anxiety
□ Anger/Rage
□ Thoughts of harming others
□ Racing Thoughts
□ Hallucinations
□ Violence
□ Suicide Attempts
□ Hospitalization
□ Mood Swings
□ Death in Family
□ Obsessive/Intrusive Thoughts
□ Weight gain/loss

Have you ever been in counseling before? □ Yes □ No

If yes, please complete the section below.

Dates	Counselor Name

Are you currently taking behavioral health medications? □ Yes □ No

If yes, please list:

Have you ever taken behavioral health medications in the past? □ Yes □ No

If yes, please list:

Mental Health History Continued

Have you ever been admitted into a hospital for behavioral health reasons? □ Yes □ No
If yes, please complete the section below.

Date(s)	Location

Is there any family history of mental health problems or suicide (attempts)? □ Yes □ No

If yes, please explain: _____

Medical Summary

Do you currently have any medical problems? □ Yes □ No

If yes, please list all symptoms and medications: _____

Do you experience physical pain that causes mental health issues? □ Yes □ No

Have you recently experienced any appetite changes? □ Yes □ No

Have you recently had a gain or loss of over 10 pounds? □ Yes □ No

What are your sleep patterns? _____

Employment/ Education Summary

Are you currently employed? □ Yes □ No
If yes, please complete the following section.

Occupation Employer Length of Employment

What is your highest level of education completed? _____

Are you currently a student? □ Yes □ No
If yes, please complete the following section.

School Program/ Grade Level

Legal Summary

Have you been arrested in the past two years? □ Yes □ No
Are you involved with a DOC/DCPP case or investigation? □ Yes □ No
Are you court ordered for services? □ Yes □ No **If no, please skip to the next section.**
Are you currently assigned to a probation officer or caseworker? □ Yes □ No
If yes: Name: Phone Number:
Will you require progress reports for legal authorities? □ Yes □ No

Substance Use Summary

Have you ever used or are you currently using any substances? □ Yes □ No

Have you ever felt guilt or remorse about your substance use? □ Yes □ No

Have you ever tried to stop and have been unsuccessful? □ Yes □ No
If yes, please complete the section below.

Date(s)	Circumstance

Family History

Who were you raised by? _____
Please describe your relationship with your parents/caregivers. _____

How many siblings do you have? _____
Please describe names, ages, and respective relationships with your siblings:

Are you living with your spouse or partner at present? □ Yes □ No
Please describe your relationship with your spouse or partner _____

Do you have any children? □ Yes □ No
If yes, please complete the section below.

Name of Child	Age	Relationship with Child

Social/ Support System

Describe your leisure/recreational activities _____

Is your current home environment safe? □ Yes □ No
If no, please explain why. _____

Who is your primary support system? _____

What do you hope to gain from treatment? _____

Please list all family members and ages that will be involved in treatment.

Patient Name (Printed) Patient Signature Date