

Child & Family Guidance Center of Texoma

Current Concerns and Client History

Adult

Client Name: _____ Age: ____ Gender M F Ethnicity: _____

Phone #: _____ Single Married Divorced Separated Cohabiting

Presenting Problem

Describe the problems you are having and when they began: _____

What do you believe has contributed to the problem? _____

What type of therapy services are you seeking? Individual Couples Family Crime Victim

<p>CURRENT CONCERNS: Please check all that apply and place a star next to the items of significant concern.</p>	<p>Mood Related Issues</p> <p><input type="checkbox"/> Disturbing memories <input type="checkbox"/> Difficulty going to sleep/staying asleep <input type="checkbox"/> Nightmares/night terrors <input type="checkbox"/> Suicidal thinking or talking <input type="checkbox"/> Irritability <input type="checkbox"/> Sadness/Depression <input type="checkbox"/> Feelings of guilt and shame <input type="checkbox"/> Excessive worrying/fear/anxiety <input type="checkbox"/> Chronic stress <input type="checkbox"/> Other (please specify) _____</p>	<p>Behavioral/Conduct Issues</p> <p><input type="checkbox"/> Anger issues <input type="checkbox"/> Aggression toward others <input type="checkbox"/> Drug/Alcohol use <input type="checkbox"/> Betraying relationships <input type="checkbox"/> Engaging in risk-taking behaviors <input type="checkbox"/> Stealing <input type="checkbox"/> Intentionally hurting animals <input type="checkbox"/> Fire-setting <input type="checkbox"/> Other unusual behaviors (please specify) _____</p>
<p>Family Relationship Issues</p> <p><input type="checkbox"/> Difficulty adjusting to family changes <input type="checkbox"/> Discipline/Parenting concerns <input type="checkbox"/> Parent-Child relationship problems <input type="checkbox"/> Estranged relationships <input type="checkbox"/> Other relationship problems <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Religious/Spiritual concerns <input type="checkbox"/> Constant fighting <input type="checkbox"/> Lonely <input type="checkbox"/> Other (specify) _____</p>	<p>Other Behavioral Concerns</p> <p><input type="checkbox"/> Sexual identity concerns <input type="checkbox"/> Inappropriate sexual behavior <input type="checkbox"/> Sexual issues in general <input type="checkbox"/> Appetite/eating concerns <input type="checkbox"/> Hyperactive/Impulsivity <input type="checkbox"/> Inattentive <input type="checkbox"/> Lying <input type="checkbox"/> Oppositional/Defiant <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Bored with life <input type="checkbox"/> Other (please specify) _____</p>	<p>Work/School Issues</p> <p><input type="checkbox"/> Learning difficulties <input type="checkbox"/> Problems with peers <input type="checkbox"/> Problems with teachers <input type="checkbox"/> Failing grades <input type="checkbox"/> Refusing to go to work/school <input type="checkbox"/> Bullying concerns <input type="checkbox"/> Time management concerns <input type="checkbox"/> Harassment issues <input type="checkbox"/> General work performance issues <input type="checkbox"/> Career dissatisfaction <input type="checkbox"/> Other (please specify) _____</p>

Treatment History:

1. Past or present counseling services received? No Yes When? _____
 Provider Name: _____ How long? _____
 Did treatment help you? No Yes
2. Past psychological evaluation: No Yes Please provide a copy of evaluation if possible.
3. Past hospitalizations for emotional/behavioral issues or alcohol/drug treatment? No Yes
 When/Where _____
4. Is there a history of mental health issues in your family? No Yes
 Please list family members: _____

Family History:

1. Who lives in your home with you? Spouse/Significant Other Children Other Relative Other
2. Do you have children? No Yes Biological Step or Half
 How many live in your home with you? _____ Ages: _____
3. Are you currently in the process of separation or divorce? No Yes
4. Who are some important people in your life? _____
5. Your life experiences growing up can affect your life. What experiences or events (divorce, grief, family violence, discipline, favoritism, trauma, affection, lack of attention, bullying, or others) have made a difference in your life?

Personal History

1. What is the highest grade you have completed? _____
2. Did you have any problems in school? ___ Academic ___ Discipline ___ Friends/Social ___ Bullying
3. Are you currently employed? ___ No ___ Yes Where? _____ How long? _____
How many hours per week? _____ Job Title: _____
4. Have you served in the military? ___ No ___ Yes How long? _____ Type of discharge? _____
5. Are you now or have you ever been involved with the legal system? (criminal, divorce, custody, civil, etc.)
___ No ___ Yes How? _____
6. Do you anticipate any future involvement with the legal system? ___ No ___ Yes
7. Have you ever been physically, sexually, or emotionally abused? ___ No ___ Yes

Social History

1. What are your most positive qualities/strengths? _____
2. What qualities/actions would you like to change about yourself? _____
3. From whom do you get emotional support? _____
4. Do you have friends? ___ No ___ Yes How do you get along with your friends? _____
5. Has there been a change in your circle of friends lately? ___ No ___ Yes
6. What have been the losses, changes, crises and transitions in your life? _____

7. Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? _____

8. Is there anything about your lifestyle (or your family or friends) that would be helpful for your therapist to know?

Medical History

1. Client's general health is? ___ Excellent ___ Good ___ Fair ___ Poor
2. List any allergies, serious illnesses, surgeries or injuries, hospitalizations: _____

3. What physical illnesses run in your family? _____

4. What is the name of your doctor? _____

Please check the following items for a current and past diagnosis received:

Diagnosis	Present	Past	Date of Diagnosis	Name of Medication	Dosage	Prescribing Physician
Depression						
ADHD/ADD						
Learning Disability						
Anxiety/Nervousness						
Panic Attack						
Manic-Depression/Bipolar						
Schizophrenia						
Mood/Anger						
Tics						
Insomnia/Sleeplessness						
Obsessive/Compulsive						
Addictions						
Convulsions						

Child & Family Guidance Center Adverse Childhood Experiences (ACE) Questionnaire Ages 18 and over

The Child & Family Guidance Center of Texoma is striving to become a fully integrated trauma informed care organization. We recognize the significance of resilience and the ability of individuals, organizations and communities to heal and promote recovery from trauma. To help us better serve you, please complete this short questionnaire concerning possible life events. Thank you!

QUESTION 1 OF 10

Before your 18th birthday, did a parent or other adult in the household often or very often... swear at you, insult you, put you down, or humiliate you?

Or
act in a way that made you afraid that you might be physically hurt?

Yes No

QUESTION 2 OF 10

Before your 18th birthday, did a parent or other adult in the household often or very often... push, grab, slap, or throw something at you?

Or
ever hit you so hard that you had marks or were injured?

Yes No

QUESTION 3 OF 10

Before your 18th birthday, did an adult or person at least five years older than you ever... touch or fondle you or have you touch their body in a sexual way?

Or
attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No

QUESTION 4 OF 10

Before your eighteenth birthday, did you often or very often feel that... no one in your family loved you or thought you were important or special?

Or
your family didn't look out for each other, feel close to each other, or support each other?

Yes No

QUESTION 5 OF 10

Before your 18th birthday, did you often or very often feel that... you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or
your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No

ACE QUIZ (CONT.)

QUESTION 6 OF 10

Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?

Yes No

QUESTION 7 OF 10

Before your 18th birthday, was your mother or stepmother:
often or very often pushed, grabbed, slapped, or had something thrown at her?

Or

sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

Or

ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No

QUESTION 8 OF 10

Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

Yes No

QUESTION 9 OF 10

Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No

QUESTION 10 OF 10

Before your 18th birthday, did a household member go to prison?

Yes No

Scoring

1 point is assigned to each "Yes" answer.

Source

<http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean>