NARANJO THERAPY

CLIENT HISTORY AND INFORMATION FORM

BASIC INFORMATION

Date:

Patient Name:

Social Security Number:

Date of Birth:

Gender: Male Female

I am (circle all that apply):
Single In a relationship Married Divorced

My sexual identity is:

Ethnicity:

Patient's Home Address:

Patient's Home Phone Number:
May we leave a message? Yes No

Patient's Work Phone Number:
May we leave a message? Yes No

Patient's Mobile Phone Number:
May we leave a message? Yes No

If the above patient is a minor complete the following:

Name of Guardian:

Address of Guardian:

Guardian's Home Phone:
May we leave a message? Yes No

Guardian's Work Phone:
May we leave a message? Yes No

Guardian's Mobile Phone:
May we leave a message? Yes No

REFERRAL SOURCE

Who referred you to our office, or how did your learn about our practice?

EMERGENCY CONTACT INFORMATION

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

HISTORY INFORMATION

Who is providing the history information?

The patient
The patient's guardian
Other:

PREVIOUS TREATMENT

Have you received or participated in previous counseling and/or therapy? Yes No

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns? Yes No

Are you currently experiencing thoughts of harming either yourself or someone else? Yes No

Have you in the past experienced thoughts of harming either yourself or someone else? Yes No

CURRENT SYMPTOMS

Please describe the current complaint or problem as specifically as you can, in your own words:

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

CIRCLE ALL WORDS/PHRASES THAT DESCRIBE WHAT YOU ARE EXPERIENCING:

Substance abuse/dependence

Addiction (Internet, porn, shopping, exercise, gaming, gambling, etc.

Depression/Sad/Down feelings

High/Low energy level

Angry/Irritable

Loss of interest in activities

Difficulty enjoying things

[ ] Crying spells

Decreased motivation

Withdrawing from people/Isolation

Mood Swings

Black and white thinking/All or nothing thinking

Negative thinking

Change in weight or appetite

Change in sleeping pattern

Perfectionism

Suicidal thoughts or plans/Thoughts of hurting yourself

Self-harm/Cutting/Burning yourself

Homicidal thoughts or plans/Thoughts of hurting others

Poor concentration/Difficulty focusing

Feelings of hopelessness/Worthlessness

Feelings of shame or guilt

Feelings of inadequacy/Low self-esteem

Anxious/Nervous/Tense feelings

Panic attacks

Racing or scrambled thoughts

Bad or unwanted thoughts

Flashbacks/Nightmares

Muscle tensions, aches, etc.

Hearing voices/Seeing things not there

Thoughts of running away

Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

Feelings of frustration

Feelings of being cheated

Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

Distorted body image (believe you are heavier or less attractive than others say you are)

Concerns about dieting

Feelings of loss of control over eating

Binge eating/Purging

Rules about eating/Compensating for eating

Excessive exercise

Indecisiveness about career

Job problems

Other:

DEVELOPMENTAL HISTORY

Are you aware of any difficulties or complications during the time your mother was pregnant with you? Yes No (If yes, explain):

Did you walk, talk, and read on time? Yes No (If yes, explain):

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? Yes No

Are you satisfied at where you are in your life? Yes No (If Not, where would you like to be):

MEDICAL HISTORY

List any current or important past medications:

Medication & Dose:

History of chronic illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime:

Have you experienced any head injuries? Yes No (If yes, explain below) If yes, did you lose consciousness? Yes No

Have you experienced convulsions or seizures? Yes No (If yes, explain below) If yes, did you also have a fever? Yes No

List any allergies you have:

How well do you manage any chronic conditions you have:

How would you rate your current physical health (circle one)?

Excellent

Very Good

Good

Fair

Poor

Very Poor

What was the date of your last physical or routine health "check up?":

Do you have a primary care physician? Yes No (If yes, complete the following):

Name

Address

Phone Number

Do you have a specialty physician (e.g. Endocrinologist)?

Yes No (If yes, complete the following):

Name

Address

Phone Number

FAMILY HISTORY

Birth Location:

Raised by: Mother Father Step-Mother Step-Father

Other caregiver:

Who else lived with you growing up:

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? Yes No (If yes, explain below):

Any family history of substance abuse, mental illness, suicide, or violence? Yes No (If yes, explain below):

SOCIAL HISTORY

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

EDUCATIONAL HISTORY

What is the highest educational level you have completed?

When attending school where you (circle):

In regular classes

Home Study

Special classes

Advanced classes

Ever suspended

Placed in alternative school

Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

OCCUPATIONAL HISTORY

What is your current employment status (circle)?

Employed Full-Time

Employed Part-time

Unemployed

Self-employed

Student

Other

Are you satisfied with your employment? If not, why?

SUBSTANCE ABUSE HISTORY

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other) Yes No

If you answered yes, please complete the following substance abuse history chart.

Alcohol:

Ever Used Yes/No

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

Marijuana:

Ever Used Yes/No

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

Tobacco:

Ever Used Yes/No

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

Prescribed medication in a non-prescribed way:

Ever Used Yes/No

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

Other drugs: (fill in the name)_____

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

Other drugs: (fill in the name)_____

Age of First Use

Frequency of Use (Daily, Weekly, Monthly)

Amount Used

How did you use it? (smoked, injected, etc.)

ADDITIONAL INFORMATION

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself:

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?