

JANE McCAMPBELL COUNSELING SERVICES, LLC

7975 Stone Creek Drive #130, Chanhassen, MN 55317 ▪ 4005 West 65th Street #210, Edina, MN 55435
Phone: 612.414.0383 ▪ Email: JaneMcCampbell@comcast.net ▪ Web: JaneMcCampbellCounseling.com

The information requested on this form is intended to be helpful to you and your therapist in the provision of the best possible service to you. If there is any question that you would prefer not to answer, please feel free to leave blank and discuss in session.

FULL NAME _____ Name you prefer to be called _____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

2. Did a specific event lead to this request for service? Yes No If yes, please describe the incident. _____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. _____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

6. How much does this problem affect your life? *(Please circle the number that best applies)*

	Not at all	A little bit	A lot	All the time
1. Personally	1	2	3	4
2. Family life	1	2	3	4
3. Socially	1	2	3	4
4. Work-wise	1	2	3	4

7. How were you referred to this service? *(Please circle)*

Self Spouse/Other Physician Employer Court Other *(Please specify)*: _____

8. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc)? Yes No If yes, please specify: _____

9. Do you have an involvement with any of the following people or services? Yes No If yes, please circle all that apply:

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum Worker's Compensation

If so, please describe. _____

Contributing Factors

10. Which of the following do you think contribute to your problem(s)? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Family move to a new home | <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Developmental problems |
| <input type="checkbox"/> Adjustment to sitter/day care | <input type="checkbox"/> Birth of child or sibling | <input type="checkbox"/> Suspect physical/sexual abuse |
| <input type="checkbox"/> Parental quarreling/arguing | <input type="checkbox"/> Adjustment to school | <input type="checkbox"/> Known physical/sexual abuse |
| <input type="checkbox"/> Post-divorce adjustment | <input type="checkbox"/> School problems | <input type="checkbox"/> Law violations |
| <input type="checkbox"/> Financial stress | <input type="checkbox"/> Absenting home or school | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Marital unfaithfulness | <input type="checkbox"/> Negative peer influence | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Separation of parents | <input type="checkbox"/> Medical problems | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Remarriage of parent | <input type="checkbox"/> Drugs or alcohol use | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Career change | <input type="checkbox"/> Empty nest |
| <input type="checkbox"/> Spiritual problems | <input type="checkbox"/> Previous therapy | <input type="checkbox"/> Other: _____ |

Symptoms

11. Please look these items over and circle the number that best describes how these symptoms have bothered you **recently**.

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad, or crying	1	2	3	4
2. Guilty feelings	1	2	3	4
3. Suicidal thoughts, plans, or attempts Have you <i>ever</i> thought about, planned or attempted suicide? Thought about Y N Planned Y N Attempted Y N If yes to any of these, when was this? _____	1	2	3	4
4. Changed sleep patterns <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Can't get up in a.m. <input type="checkbox"/> Nightmares	1	2	3	4
5. Change in weight or eating habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
6. Loss of interest or energy	1	2	3	4
7. Anxious, nervous, or panicky feelings	1	2	3	4
8. Avoiding places or situation	1	2	3	4
9. Repetitive thoughts or behaviors	1	2	3	4
10. Change in work habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
11. Anger or temper problems	1	2	3	4
12. Insecurity or inferiority	1	2	3	4
13. Physical problems, pain, or illness	1	2	3	4
14. Sexual worries or problems	1	2	3	4
15. Change in spending habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
16. Memory problems	1	2	3	4
17. Confused or disorganized thoughts	1	2	3	4
18. Hallucinations	1	2	3	4

Mental Health & Medical History

12. Who is your primary care physician and your primary clinic? _____

13. Who else do you regularly see as part of your routine health care? _____

14. List any significant health problems, past or present, including surgeries and/or illnesses with the *corresponding dates*.

15. Are you currently taking any medications? Yes No If yes, please list:

Medication	Dose and number of pills you take per day (e.g. .25 mg. 3 times per day)	Prescribing doctor

16. Have you ever taken any medications for depression, anxiety, or mental health issues? Yes No If yes, please list:

Medication Name	Prescribed for? (eg: depression, anxiety)	When (approx)	How long were you on the medication?	Prescribing doctor

17. Do you have any allergies to medications? Yes No If yes, please list and describe the reaction. _____

18. List other therapy or counseling you have received in the past or are receiving now:

Therapist's name	Address	Approximate dates

19. If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form. To receive a Release of Information form, please check here .

20. Have you ever been hospitalized for mental or nervous problems? Yes No If yes, when and where? _____

Substance Use

21. Please describe your use of the following substances:

	Daily	Weekly	Occasionally	In the past but not now	Not at all
Caffeine					
Tobacco					
Alcohol					
Prescription drugs					
Inhalants					
Street drugs					
Over-the-counter medications					
Other: _____					

22. Have you ever experienced any of the following as a result of substance use?

Blackouts Bad reactions Withdrawal symptoms Overdose DUI Other: _____

Please give details _____

23. Have you ever felt you should **cut down** on your drinking or drug use? Yes No

24. Have people **annoyed** you by criticizing your drinking or drug use? Yes No

25. Have you ever felt bad or **guilty** about your drinking or drug use? Yes No

26. Have you ever had a drink or used drugs as an **eye-opener** first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? Yes No

27. Have you ever had treatment for any type of alcohol or substance use? Yes No If yes, when? _____

Please describe: (*Include inpatient, outpatient, detox*): _____

Resources

28. What has helped you manage or endure your current problem? _____

29. Please describe the people in your life that currently play a supportive, influential, or friendship role. _____

30. What interests or passions give meaning to your life? _____

31. Do you have any spiritual beliefs or practices that are important to you? Yes No If yes, please explain: _____

32. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? _____

Family Information

33. Please list those who you consider part of your immediate family and/or your current household.

Name	Age	Relation to you	Living with you?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Other

34. Is there anything else that you would like your therapist to know and that you have not written about on any of these forms?

Yes No If yes, please tell me about it here or on another paper: _____

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform Jane McCampbell of any changes in my personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Client Signature _____ Date _____