STONE CITY COUNSELING, Inc.
2325 Q Street
Bedford, IN 47421
Phone (812) 279-HOPE (4673)
Fax (812) 279-**4672**

BIOPSYCHOSOCIAL DATA:

*****please feel free to put N/A or don't know or draw a line through any question unrelated to you**

Current Relationship Status (please circle): Married Partnered Divorced Single Widow(er)

Number times married and divorced _____ Number times cohabitated and separated when partnered_____

Past Mental Health Treatment:

Date Started	Date Ended	Location	Reason for Treatment

Substance Use History—Past/Current: Please inform us of the following:
How old when you first tried drugs_____ and/or alcohol_____
Current substance(s) of use (please list all) _____
When did you first begin to use each substance:_____
Frequency of use:_____
Do you feel your use has become a problem for you? Please circle Yes or No. (You may elaborate at session with therapist if necessary.)

Please report any family history of substance abuse/dependence *for instance list any relatives including biological aunts, uncles, grandparents:
_____

Please list any family members you are aware of who have had mental/emotional or behavioral illness, (for example: anyone who has committed suicide even if it is someone you have not met but have been related biologically
_____

Have you had any traumatic events in your life?: *You may elaborate on this in session but for now please at a minimum state yes or no*
_____

Please inform us of how far you have gone in traditional academia. *For instance did you graduate from high school or college, receive a GED, complete vocational school* _____

Please describe family of origin: Did your mom and dad stay married_____. Did both parents raise you_____if not, which parent was involved_____. If neither parent who, was your guardian_____. How many siblings _____Were they male or female please list_____Of what birth order are you_____

Please briefly describe any history of physical or sexual abuse *(you will have a chance to discuss or not with clinician)*:
_____

Please list any MEDICATIONS you currently take, even if they are over the counter, in the chart below:

Name	Dosage	Prescribed by who?

Please list any allergies/medical conditions: _____

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Please list current support systems (people you go to when you need help): _____

_____

List ALL household members in the chart below: **How long have you lived at current residence:** _____

Name	Age	Relationship

Are you currently employed? If so, where?: _____ **How long:** _____
Length of longest employment: _____

Have you ever been arrested (when and what was the charge): _____

_____

Clinical/Diagnostic Data

Please check any symptoms you are **CURRENTLY** experiencing. **When did symptoms begin:** _____

Suicidal Ideation (SI)		**Poor Self Care**		**Crying More Frequent**	
Homicidal Ideation (HI)		**Anxiety Attacks**		**Depressed mood most of the day**	
SI with a Plan		**Reoccurring Thoughts**		**Nervous Around People**	
HI with a Plan		**Hearing Things that aren't there**		**Smelling Items**	
SI with a Plan and Intent		**Changes in Sleep**		**Problems with Drugs**	
HI with a Plan and Intent		**Changes in Appetite**		**Problems with Alcohol**	
Thoughts of Harm		**Unable to Perform Tasks**		**Seeing Things**	
Intrusive Thoughts		**Dizziness (not medical)**		**Hallucinations**	
Nightmares		**Hopelessness**		**Depression**	
Anger/Irritability		**Feelings of guilt**		**Low self-esteem**	
Trouble concentrating/focusing		**Memory problems**		**Racing thoughts**	
Weight loss or gain		**Worthlessness**			
Impulsivity		**Hypervigilance**		**Decreased interest in activities you used to enjoy**	

Please explain any other information you feel is important for therapist to know:

_____

_____

Please briefly list goals for treatment _____

_____

_____

Client Signature _____ **Date:** _____