HEARTLAND COUNSELING & CONSULTING CLINIC

CLIENT HISTORY QUESTIONNAIRE

DATE:

CLIENT NAME:

CLIENT AGE:

COMPLETED BY:

(Parents: Please complete this form for your child. If a question does not apply, mark it "n/a")

Did anyone refer you to Heartland Counseling? If so, who?

Please describe the problems that led you to coming to seek assistance:

What do you hope to gain from this service (that is, what do you want to be different in your life?)?

BEHAVIORAL HEALTH HISTORY/URGENT NEEDS

Have you ever been hospitalized for mental health reasons? **Yes / No**

If yes, please explain, including where, why, and when you were hospitalized.

Have you ever been on a Mental Health Board Commitment? **Yes/No**

Have you ever been placed in Emergency Protective Custody? **Yes/No**

Do you have any thoughts of suicide now or in the recent past? **Yes/No**

Have you ever attempted suicide? **Yes/No**

Have you ever harmed yourself (cutting, scratching, burning, etc.) as a way to deal with emotions or stress (*not* as a suicide attempt)? **Yes/No**

If yes, please explain:

Are you having thoughts of harming others now or in the recent past? **Yes/No**

If yes, please explain:

Do you have a history of violence toward others? **Yes/No**

If yes, please explain:

Do you carry any weapons or keep any weapons in your home? **Yes/No**

If yes, please explain:

What are your coping skills? (what do you do that helps you through hard times?)?

Who would you contact or what would you do to help you get through a crisis?

SUBSTANCE USE

Have you ever abused alcohol or drugs of any kind? **Yes / No**

If yes, please answer the following:

What substance(s) did/do you abuse?

How old were you when you started using each substance?

What is your longest period of abstinence from using each substance?

Do you think you have a current drug or alcohol problem? **Yes / No**

If yes, describe your current usage:

What substance?

How much (quantity)?

How often (frequency)?

Are you currently experiencing any symptoms of withdrawal?

Do you have a history of IV drug use? **Yes / No**

If yes, please explain.

Do you use tobacco? **Yes / No**

If yes, how much per day?:

Cigarettes?

1 to 2 packs, Half a pack to 1 pack, Less than half a pack, More than 2 packs, No use

Chew?

1 to 2 cans of chew, Can of chew,Less than can of chew, More than 2 cans of chew, No Use

Cigars?

1 cigar,1 to 2 cigars,3 cigars, No use

Pipe?

2 or less fills of pipe, More than 2 fills of pipe, No use

During the last 12 months, have you stopped smoking for one day or longer because you are trying to quit? **Yes / No / N/A**

Are you aware of the free telephone counseling to help tobacco users quit? (Nebraska Tobacco Quitline) **Yes / No / N/A**

Have you attempted to use this line to help you quit? **Yes / No / N/A**

How much time since you last smoked a cigarette, even one or two puffs?

Within the last 24 hours Within the last 3 days Within the last week
Within the past month (less than 1 month ago)
Within the past 3 months (More than 1 month but less than 3 months ago
Within the past 6 months (More than 3 months but less than 1 year ago)
Within the past year (More than 6 months but less than 1 year ago)
More than one year ago Never smoked regularly Don't know/Not sure

About how many caffeinated beverages do you drink per day (in cups or ounces)?

Do you think you have a current problem with gambling? **Yes/No**

If yes, answer the following:

Is gambling causing problems in your relationship and/or finances?

How often do you gamble?

How much money are you spending monthly on gambling?

CURRENT/HISTORY OF TREATMENT

Are you currently receiving any mental health OR substance abuse services? **Yes/No**

If yes, what type of services?

With whom?

Have you ever received mental health OR substance abuse treatment before (including residential treatment, counseling, medication treatment or any other type)? **Yes/No**

If yes, what type of treatment?

With whom?

Where?

When?

Was it helpful?

Thinking about your mental health which includes stress, depression and problems with emotions, for how many days during the past 30 days would your mental health NOT good? _____ (0-30)

LIVING SITUATION

Please describe your current living situation (what type of home, who lives with you, etc.):

How would you rate your housing conditions? Good,Fair,Poor

Have you moved frequently in your lifetime? **Yes / No**

If so, please explain, including the approximate number of moves.

Would you like any changes to your current living situation? **Yes/No**

If yes, please explain:

FAMILY HISTORY

Where were you born?

Please describe your family of origin (parents, siblings, who you were raised by, where you grew up, etc.):

Have there been any deaths, separations, divorces, or incarcerations of your parents or other family members? **Yes/No**

If yes, please explain:

Did anyone in your family have a history of mental health concerns and/or treatment? **Yes/No**

If yes, please explain:

Did anyone in your family have a history of substance use concerns and/or treatment? **Yes/No**

If yes, please explain:

What did you parents do for work when you were growing up?

RELATIONSHIPS

Do you have any sexual or sexual development issues (sexual orientation, fertility, dysfunction, gynecological issues, etc.) relevant to your treatment? **Yes / No**

If yes, please explain.

Do you have any children? **Yes / No**

If so, please list names and ages.

Have there been any deaths, separations, divorces, or incarcerations of your parents, family member or significant others? **Yes / No**

If yes, please explain.

Do you have a religious preference? **Yes / No**

If so, please describe.

Were there any delays in your childhood development (gross or fine motor coordination, language us, speech, social skills, etc.)? **Yes / No**

If yes, please explain.

To your knowledge, did your mother receive prenatal care? **Yes / No**

Were there any complications with your birth? **Yes / No**

If yes, please explain.

Did you reach developmental milestones (walking, talking, toilet training, etc.) at the typical ages? **Yes / No**

If no, please explain.

Who is included in your support system (who can you count on?)?

What did your parent(s) do for employment when you were growing up?

Is there any history of mental illness and/or treatment in your family? **Yes / No**

If yes, please explain.

Is there any history of substance abuse and/or treatment in your family? **Yes / No**

If yes, please explain.

Do you have a history of injuries, illnesses, or disabling conditions? **Yes / No**

If yes, does this result in any physical limitations or need for assistive technology? **Yes / No**

Do you have any current medical concerns or dental needs? **Yes / No**

If yes, please explain.

(For clients 18 and under) Are your immunizations up-to-date? **Yes / No**

Has yearly health check screen been completed? **Yes / No**

Please list physician and date

IF you take medications on a daily basis:

Do you have any difficulty remembering to take your medications? **Yes / No**

Do you use a medication box or bubble pack? **Yes / No**

Do you have a history of abuse (including emotional, verbal, physical, sexual abuse as a child or as an adult, neglect, history of sexual assault, witness to domestic violence, financial exploitation, etc.)? **Yes / No**

If yes, please explain, as much as you feel comfortable.

Have you ever been exposed to any other kind of trauma (including natural disasters, war, accidents, traumatic loss of a loved one, life threatening illness, etc.)? **Yes / No**

If yes, please explain, as much as you feel comfortable.

Have you been the victim of any crimes? **Yes / No**

If yes, please explain.

Do you have any current legal issues? **Yes / No**

If yes, please explain.

Do you have any history of arrests, incarcerations, or probation? **Yes / No**

If yes, please explain.

Do you have a history of legal charges related to violence toward people or property? **Yes / No**

If yes, please explain.

Do you keep any weapons in your home? **Yes / No**

If yes, please explain.

FUNCTIONAL DEFICITS

Vocational/Educational:

Please describe any current employment or volunteer work:

Please describe your employment history (types of jobs you've had, longest length of employment, last time you had a job if you are currently unemployed, etc.)

Have you ever been let go from employment because of your behavior (for example, attitude, tardiness, missing work, personal problems, injury, substance abuse, etc.)? If yes, please explain.

What is the highest grade you completed in school?

What were your average grades when you were in school?

Do you know your IQ? **Yes / No**

If so, please list.

In school, did you have any learning disabilities, behavioral disorders, or need for special education? **Yes / No**

If yes, please explain.

(For clients 18 and under) How much school do you usually miss?

1 day or less per month,1 day every 2 weeks, 1 day per week, 2 or more days per week

Have you attended any college or vocational training? **Yes / No**

If yes, please describe.

Do you have any military history? **Yes / No**

If yes, please describe.

Do you have any desire to change anything in regard to your employment or educational status? **Yes / No**

If yes, please explain.

Social Skills:

Do you feel lonely and/or isolated in life? **Yes / No**

If so, please explain.

Are you involved in any social activities (support groups, organizations, religious activities, 12-step programs, etc.)? **Yes / No**

If yes, please describe.

Do you have any current problems with friendships or relationships in general? **Yes / No**

If so, please describe.

Activities of Daily Living:

How often do you shower/bathe?

How often do you do laundry?

Do you eat regular meals? **Yes / No**

Are you able to keep up with your own personal business affairs (bill paying, appointment-making, etc.)?
Yes / No

What do you do for transportation?

How do you feel you do with housework and household upkeep?

Do you have any medical, legal, or housing needs that you are having trouble meeting? **Yes/No**
If yes, please explain.

What is your current height and weight? Height _____ Weight _____

CLINICAL INFORMATION

Please any of the symptoms that you are have experienced in the last month:

- ☐ hearing voices that other people don't hear
- ☐ tearfulness
- ☐ hopelessness/helplessness
- ☐ loss of interest or pleasure
- ☐ trouble with sleep (too much or not enough)
- ☐ appetite changes (increased or decreased)
- ☐ change in energy level (increased or decreased)
- ☐ reduced motivation level
- ☐ feeling badly about yourself or excessively guilty
- ☐ feeling slowed down physically
- ☐ thoughts of death
- ☐ feeling overly hyper or euphoric
- ☐ being extremely irritable, easily frustrated
- ☐ trouble with concentration, focus, and decision making
- ☐ involvement in risky behaviors that are out of character for you
- ☐ increased impulsive behavior
- ☐ excessive worry
- ☐ feeling stressed out and overwhelmed
- ☐ racing thoughts
- ☐ nightmares
- ☐ flashbacks to traumatic events
- ☐ extreme feelings of fear or panic
- ☐ feeling keyed up, on edge
- ☐ disturbing obsessive thoughts
- ☐ muscle tension, headaches, stomach aches related to stress

- ☐ hearing voices that other people don't hear
- ☐ seeing things that other people don't see
- ☐ feeling paranoid or persecuted

Other symptoms not listed above:

How long have you been having the above-listed symptoms?

What do you see as your primary NEEDS (what would make your life better?)?

What do you see as your personal STRENGTHS (what is good about you or your life?)?

What do you see as your LIMITATIONS (weaknesses)?

Can you think of anything (POTENTIAL PROBLEMS) that might interfere with your ability to participate in or benefit from treatment?

What are some of your ABILITIES and/or INTERESTS (what are your skills; what do you do for fun?)?

Do you have any PREFERENCES for your treatment (requests that will make treatment more helpful or feasible for you—scheduling requests, financial arrangements, etc.)?

In order to **submit** the completed Client History form to Region II Human Services, please follow the below steps.

1. **Please complete the form to the best of your ability.**
2. **After the form is completed, RIGHT CLICK on the form and click on SAVE AS to save the completed form to your computer or tablet.**
3. **Email the completed form to teresa@r2hs.com**

Forms.OP.09.