Counseling with Jess

Jess Albright, LCPC, ACS

Licensed Clinical Professional Counselor

Personal Information

Name: _____

Age: _____ Date of Birth:_____

Address:

_____

_____

Phone: (home)_____

(cell) _____

(work) _____

E-mail: _____

Name of PCP: _____

Phone number: _____

History Questionnaire

Main Concerns: _____

_____

_____

_____

When did you first notice the problem? _____

_____

List any previous therapy or psychiatric consultation or treatment.

Provider name: _____

Dates of treatment: _____

Previous diagnoses: _____

Was it helpful? Why or Why not? _____

_____

Please indicate all medications and dietary supplements currently taken.

Medication and dosage	Diagnosis	Date of initial prescription
_____		
_____		
_____		
_____		

Do you have any illnesses? _____

_____

Social/Emotional/Behavioral Functioning

Please indicate if you are currently struggling in any of the following areas.

____ Depressed mood
____ Feel hopeless/helpless
____ Socially withdrawn
____ Less interested in fun activities
____ Suicidal thoughts
____ Increased crying
____ Anxiety/Worry
____ Sleep difficulty/nightmares
____ Indecisive
____ Avoids conflict
____ Racing thoughts

____ Decreased energy
____ Low self-esteem
____ Poor concentration
____ Thoughts of death
____ Sexual problems
____ Mood swings
____ Panic attacks
____ Avoids crowds
____ Rigid thinking
____ Perfectionist
____ Irritable mood

____ Intense fear

____ Compulsive behavior

____ Temper outbursts

____ Disordered eating

____ Impulsive

____ Obsessive thoughts

____ Reckless or self-abusive behavior

Please indicate which of the following have been experienced in members of your immediate and/or extended family.

	Relationship to You (maternal/paternal)
☐ AIDS	_____
☐ Alcoholism	_____
☐ Anxiety	_____
☐ ADHD/ADD	_____
☐ Autism Spectrum Disorder	_____
☐ Bipolar Disorder	_____
☐ Birth Defects	_____
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Drug Addiction	_____
☐ Eating Disorder	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ Intellectual Deficiency	_____
☐ Learning Disability	_____

☐ Psychiatric Hospitalizations _____

☐ Suicide _____

(threats, attempts, completed)

☐ Other (specify: _____) _____

Additional Comments

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire thoroughly!