ICARD, PLLC
Client History Information Form

Date: ____________________

Client's Name: ____ Gender:____ Date of Birth:__________ Age: ____

Address: ____ City: _____________ State: ___ Zip: _________

Cell Phone: (___) ___________________ Work: (___)__________________ Home: (___)________________

E-mail Address: ____

Marital status: Single / Married / Partnered / Living Together / Separated / Divorced

Spouse Name____Phone: (___)________________

Emergency Contact ____

Relationship: ____ Phone: (___)________________

Referred By: ____ Phone: (____)__________________

Reason for Referral: ____

____

Primary Care Physician: ____ Phone: (____)_________________

Address: ____ City: _____________ State: ____ Zip: __________

Family Information:

**If you have children please list below.

Name (Circle One)	Age	Gender	Comments/Quality of Relationship
(Biological, Adoptive, Step, Foster)			
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(Biological, Adoptive, Step, Foster)			

Tell me about your family. (What do you like to do as a family? What do you do well as a family? What are your struggles as a family?)

Did anyone in your immediate family or other relatives have any of the following? (If so, who? Parents, grandparents, aunts, uncles, brothers, sisters, cousins, etc.):

Alcoholism	Yes	No	Who?
Asthma	Yes	No	Who?
Depression	Yes	No	Who?
Diabetes	Yes	No	Who?
Emotional Problems	Yes	No	Who?
Headaches (Migraine)	Yes	No	Who?
Hearing problems (not due to aging)	Yes	No	Who?
High Blood Pressure	Yes	No	Who?
Hyperactivity	Yes	No	Who?
Learning or reading problems	Yes	No	Who?
Intellectual Disability	Yes	No	Who?
Muscle Disease	Yes	No	Who?
Neurological Disease	Yes	No	Who?
Sexual Abuse/Trauma	Yes	No	Who?
Seizures (epilepsy, convulsions)	Yes	No	Who?
Speech/language delays/disorders	Yes	No	Who?
Motor delays/difficulty in walking	Yes	No	Who?
Similar problems to person	Yes	No	Who?
Visual problems	Yes	No	Who?

Does any disease run in the family?.........................Yes_____ No______ If yes, what? ___________________________

Please list any unusual and/or traumatic family event in your life which you feel may have affected your development and ability to function (i.e., birth of a sibling, deaths in the family, divorce, illness, frequent school changes, moves, exposure to domestic violence, molestation, sexual abuse etc.)

Incident Age at time Comments

____

____

____

Medical History

Surgeries: ____

Injuries: ____

Currently medications (include dosage given and reason for taking it):

____

____

School History

Legal History

Social/Emotional History

What do you do for fun?

What do you do to relieve stress?

What are your interests?

How do you pass the time?

Tell me a bit about your friends...

Reason for coming to Counseling

Please tell me in your own words why you would like to come and what you would like to see different. Please include any known reasons or causes for the way you feel.