Rhonna W. Phillips
Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY FOR INDIVIDUAL INTAKE ASSESSMENT

Client Name: _____ Intake date: _____

Preferred or nickname: _____ DOB: _____ Age: _____

Address: _____ City _____ State: ___ Zip _____

Cell Phone: _____ Home Phone: _____ IDs Gender as: _____

Ethnicity as: _____ Country born in: _____

Highest Grade/degree completed: _____ Major:_____

Current School: _____ for _____

Military service? You or close relative? _____

Current Job: _____ Co: _____ How long? ____

Currently living with? _____ Referred by: _____

Problem? "_____"

Event that triggered appt: _____

Attach separate notes if you prefer to write more detail. If your counseling is Conjoint, only submit what you are willing to share with other session members.

SOCIAL & CURRENT INTIMATE RELATIONSHIP:

Circle current intimate relationship status: Dating, Girl/Boyfriend, Live together, Marriage # _____

Year/Age Met _____ ____ where _____

Year/Age began Dating _____ ____

Year/Age Lived together _____ ____

Year/Age Married_____ _____ partner was age _____ # yrs married _____

Who else resides w/you? _____ Names/Gender/Age of kids biological to you both:

_____ _____ _____

Partners' kids: _____ _____

_____ _____

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First Sig relationship/ Marriage: Year met _____ At _____You were age ____

Year dated _____ you were age _____

Year lived together _____ you were age ____

Year married _____ you were age ____ # yrs married _____

# of years divorced _____ Why did the rel end? _____

Children's Names/Gender/Age: _____

_____Stepchildren from this relationship- Names/Gender/Age:

_____

Which of these children visit w/you now? _____

Second Sig relationship/ Marriage: Year met _____ At _____ You were age ____

Year dated _____ you were age _____

Year lived together _____ you were age ____

Year married _____ you were age ____ # yrs married _____

years divorced _____ Why did the rel end? _____

Children's Names/Gender/Age: _____

_____Stepchildren from this relationship- Names/Gender/Age:

_____

Which of these children visit w/you now? _____

Other Significant Intimate Relationships past or present _____

_____

Age 1st sexually active ____ Sexual identity _____

sex partners in past 6 mos _____

Happiest memory of any intimate relationship _____

Worst memory of any intimate relationship's _____

Any: Domestic Violence Y/N _____

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Legal Probs Y/N _____ Arrests Y/N _____

DUI Y/N _____ Court Dates _____ Name of Lawyer_____

Court orders _____ Name of Probation officer _____

_____

Lawsuits Y/N _____ $ Concerns Y/N _____

Child Support paid & current or unpaid_____

Attach additional notes if needed to explain above.

FAMILY OF ORIGIN:

Support system is: _____ Religion: Raised_____,

Current Religion: _____ Attend: _____

Parents Married _____ yrs, If Divorced you were age _____ You lived w/ _____

Mother remarried Y/N #____ Father Remarried Y/N #_____ Contact w/ non

custodial parent was: _____ Relationship

w/ Step Fa was: _____ _____ w/ Step Mo was: _____

_____ _____

Bio Siblings: Name/Gender/Age: _____ _____

_____ _____ _____ _____

½ sibs or Step sibs Name/Gender/Age _____ _____

_____ _____ _____ _____

Happiest memory of childhood _____

Worst memory of childhood _____

History of Abuse: Verbal Y/N Emotional Y/N Physical Y/N Sexual Y/N Explain:

_____

_____

_____

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MENTAL/ HEALTH TREATMENT:

Alcohol use:

Beer # per day _____ per week_____ Wine # per day _____ per week_____

Hard Liquor # per day _____ per week _____ Last Marijuana use _____

Substances that you use socially/ recreationally: _____

Freq per day _____ week _____ Substances you abuse: _____

Freq per day _____ week _____ Have you or anyone close to you ever been concerned about your Alcohol or substance use? _____ Tobacco use per day _____

Past Psychiatric treatment Y/N:

Dr. _____for _____ Yr _____

Dr. _____ for _____ Yr _____

If any Residential treatment or Psychiatric hospitalizations please list, by date, on separate paper

Mental health Counselors: If considering a change why? _____

Current _____ Since_____ for _____

Counselor _____Year_____ for _____

Counselor _____ Year _____ for _____

Counselor _____ Year _____ for _____

Family Mental Health History: (Depression, Anxiety, Substance Abuse, Suicide Attempts, Hospitalizations, etc)

Mother: _____ Maternal Grandparents:_____

Aunts/Uncles: _____ Cousins: _____

Father: _____ Paternal Grandparents:_____

Aunts/Uncles:_____ Cousins: _____

Siblings: _____ Kids: _____

Any past or present Medical Conditions: _____

chronic conditions _____ Hosp: _____ Surgeries: _____

Allergic to any RX? _____

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Past Medication: _____ for_____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

Current Medication, Herbs & Supplements, include contraception:

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

Add separate page if additional space is needed

Any other important information to share: _____

_____

_____

_____

OFFICE NOTES: Potential Tx Goals: _____

_____

_____

_____

_____

Plan _____

HMWK _____ RTC _____

_____ _____

Rhonna W. Phillips, MA Date

Licensed Professional Counselor & Supervisor

Licensed Marriage and Family Therapist

Collaborative Practitioner

Qualified Family & Domestic Relations Mediator Rev. 01-2018

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