Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

FAMILY BACKGROUND INFORMATION FORM—ADULT

This form is to provide detailed personal history information about you and your history so your therapist can better serve you. Please complete the following information thoroughly. This form is confidential and will be securely maintained as part of your clinical file.

CLIENT INFORMATION

Today's Date: _____ Date of First Session: _____

Full Name:			Preferred Name:
Date of Birth:	Age:	Sex: ☐ Male ☐ Female	
Occupations(s):			Total household income:
Place of Employment:			City:
Highest Grade of Education:		Degree/Diploma(s):	
How did you hear about us?			
Please Share electronic communication (Facebook, "X", Snapchat, Instagram, etc.) that you use:			
CONTACT INFORMATION			
Address:			
City:		State:	Zip Code:
Email:			
PHONE	Home Phone:		☐ OK to leave message
	Cell Phone:		☐ OK to leave message
	Work Phone:		☐ OK to leave message
EMERGENCY CONTACT INFORMATION			
Name:		Relationship:	Phone:

CURRENT HOUSEHOLD AND FAMILY INFORMATION

(Please list **all** immediate family members and, if additional space is needed, please list on back of form)

Name	Relationship (parent, sibling, etc.)	Age	Sex	Type (bio, step, etc.)	Living With You
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

Name	Relationship (parent, sibling, etc.)	Age	Sex	Type (bio, step, etc.)	Living With You
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem that has brought you in for counseling: _____

_____

How long have these issues been troubling you? _____

Are there situations that cause the issues to get worse? ☐ Yes ☐ No — IF YES, please describe:

_____

Are there situations that cause the symptoms to improve/subside? ☐ Yes ☐ No — IF YES, please describe:

_____

What would you like to see happen as a result of counseling? _____

_____

Is there any crises in your life right now (danger, family reunions, tests, death, etc.): ☐ Yes ☐ No

IF YES—please list: _____

_____

COUNSELING / MEDICAL HISTORY

Have you previously seen a counselor? ☐ Yes ☐ No

IF YES: Where and with whom? _____

Approximate dates of counseling: _____

For what reason did you go to counseling? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Have you ever received a mental health diagnosis? ☐ Yes ☐ No

IF YES—please explain: _____

Have you ever seriously considered or attempted suicide? ☐ Yes ☐ No

IF YES—please explain: _____

Have you ever taken medication for a mental health concern? ☐ Yes ☐ No

IF YES—please explain: _____

Please list below the name of medication, dates taken and its effectiveness.

Name of Medication	Dates Taken	Prescribing Physician	Was it helpful ?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Current physician: _____ Phone: _____

Hospital: _____

Address: _____

Date of last medical exam: _____

If female, what are your menstrual cycles like? _____

Have you ever had a head injury? ☐ Yes ☐ No — IF YES, please explain: _____

Have you ever been hospitalized? ☐ Yes ☐ No — IF YES, please explain: _____

Have you ever had any surgeries? ☐ Yes ☐ No — IF YES, please explain: _____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No — IF YES, please explain:

Please list all **current** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

Please list all **past** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

Do you have any allergies? ☐ Yes ☐ No — IF YES, please list: _____

Have you ever had a hearing exam? ☐ Yes ☐ No | Have you ever had an eye exam? ☐ Yes ☐ No

Please describe any problems discovered from these exams: _____

Are you **currently** taking any medications? ☐ Yes ☐ No

IF YES, please list the name of medication, dosage, prescribing physician and purpose:

Current Medication	Dosage	Prescribing Physician	Reason for Taking

Are any of your family members **currently** taking any medications? ☐ Yes ☐ No

IF YES, please list the name of medication, dosage, prescribing physician and purpose:

Current Medication	Dosage	Prescribing Physician	Reason for Taking

HEALTH • WELLNESS • LIFESTYLE

How would you rate your current physical health? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

How would you describe your current sleep/rest? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

On average, how many hours of sleep do you receive daily? _____

Do you have trouble falling asleep at night? ☐ Yes ☐ No

IF YES—please explain: _____

_____

IF YES—How long has this been a problem? _____

How would you describe your eating habits overall? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

Describe your appetite (during the past week): ☐ Poor Appetite ☐ Average Appetite ☐ Large Appetite

Please explain: _____

_____

Do you eat balanced meals regularly? ☐ Yes ☐ No

Do you worry you have lost control over how much you eat? ☐ Yes ☐ No

Would you say that food dominates your life? ☐ Yes ☐ No

Do you make yourself sick because you feel uncomfortably full? ☐ Yes ☐ No

Do you believe yourself to be fat when others say you are too thin? ☐ Yes ☐ No

Have you recently lost more than 15 pounds in a three-month period? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No IF YES—types(s): _____ How often? _____

CHEMICAL USE AND HISTORY

Do you consume caffeine? ☐ Yes ☐ No IF YES—how much do you consume per day? _____

Do you currently use alcohol? ☐ Yes ☐ No

IF YES—how often: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely How much (# per time): _____

Do you currently smoke cigarettes or use tobacco? ☐ Yes ☐ No

IF YES—how much do you smoke / chew (#per day)? _____

Do you currently use any other drugs? ☐ Yes ☐ No

IF YES—what drugs do you use: _____

How often: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Have you received any previous treatment for chemical use or alcohol use? ☐ Yes ☐ No

IF YES—where did you go? _____ When? _____

What type of treatment? ☐ Inpatient ☐ Outpatient ☐ Other: _____

Please answer the following by selecting "Yes" or "No:"

Have you ever used more than 1 chemical at the same time to get high? ☐ Yes ☐ No

Do you avoid family activities so you can use drugs or alcohol? ☐ Yes ☐ No

Do you have a group of friends who also use drugs or alcohol? ☐ Yes ☐ No

Do you use drugs or alcohol to improve your emotions such as when you feel sad or depressed? ☐ Yes ☐ No

LEGAL ISSUES

Are you currently involved in any legal litigation? ☐ Yes ☐ No

IF YES—please explain: _____

Do you have any prior convictions? ☐ Yes ☐ No IF YES—please list: _____

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

FAMILY OF ORIGIN INFORMATION

Briefly describe your relationship with your parents: _____

Briefly describe your relationship with your siblings: _____

Were you adopted or raised with parents other than biological parents? ☐ Yes ☐ No

IF YES—please explain: _____

_____

Please indicate **all** that apply during your childhood growing up in your family of origin.

- ☐ Basic needs not met (food, shelter, clothes)
- ☐ Death in the family
- ☐ Violence in home
- ☐ Parental illness
- ☐ Parental/ Guardian separation &/or divorce
- ☐ Verbal abuse
- ☐ Unemployment
- ☐ Frequent moves
- ☐ Emotional abuse
- ☐ Body Image Issues
- ☐ Physical abuse
- ☐ Strong feelings of guilt or shame
- ☐ Financial stress
- ☐ Natural disaster
- ☐ Purging
- ☐ Sexual abuse
- ☐ Crime Victim
- ☐ Living in constant fear
- ☐ Weight issues
- ☐ Extreme Dieting

Other: _____

_____

To the best of your ability indicate what you know about yourself from when you were growing inside of your mother's womb to when you turned 3 years old. Please indicate **all** that apply.

- ☐ Pregnancy difficulties / abnormalities
- ☐ Walking/gross motor problems
- ☐ Alcohol/illegal drugs during pregnancy
- ☐ Overly social/friendly
- ☐ Poor attachment to parents/caregivers
- ☐ Problems sleeping as a baby
- ☐ Did not meet developmental milestones
- ☐ Medication during pregnancy
- ☐ Difficulties during pregnancy
- ☐ Speech/language problem
- ☐ Hand coordination/fine motor problems
- ☐ Exposure to lead
- ☐ Problems eating as a baby
- ☐ Excessive fears
- ☐ Difficult to comfort
- ☐ Eating non foods
- ☐ Away from parents for a long time
- ☐ Overweight at birth
- ☐ Premature birth
- ☐ Underweight at birth

Other: _____

_____

Overall you would describe your family life growing up as (check all that apply):

☐ Supportive ☐ Negative ☐ Loving ☐ Chaotic ☐ Confusing ☐ Affirming ☐ Strict
☐ Hostile ☐ Safe ☐ Unsafe ☐ Positive ☐ Lonely ☐ Fulfilling ☐ Scary

Identify if there is a family history of any of the following. If yes, indicate the family member's relationship to you.

ISSUE	YES/NO	FAMILY MEMBER
Alcoholism/Drug Addiction	☐ Yes ☐ No	
Anxiety/Phobias	☐ Yes ☐ No	
Sexual Abuse	☐ Yes ☐ No	
Physical Abuse	☐ Yes ☐ No	
Abortion/Miscarriage	☐ Yes ☐ No	
Major Depression/Bipolar	☐ Yes ☐ No	

ISSUE	YES/NO	FAMILY MEMBER
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts/Committed	☐ Yes ☐ No	
History of Previous Counseling	☐ Yes ☐ No	
OTHER:		

CURRENT FAMILY INFORMATION

Please select your current relationship status:

☐ SINGLE ☐ MARRIED (legally) ☐ DOMESTIC PARTNERSHIP/CIVIL UNION ☐ DATING

☐ COHABITATING ☐ DIVORCED ☐ DIVORCE-IN-PROGRESS ☐ SEPARATED ☐ WIDOWED

☐ OTHER: _____

If you are currently in a relationship, how long have you been together? _____

Is your relationship an area of struggle or strength for you? ☐ Yes ☐ No

Please explain: _____

_____

If in a relationship, what is your Spouse's, Partner's, or Significant Other's first name: _____

Do you have children together? ☐ Yes ☐ No

IF YES— please list first name(s), age(s), gender, and where they live:

_____

_____

Do either of you have children from previous relationships? ☐ Yes ☐ No

IF YES— please list first name(s), age(s), gender, and where they live:

_____

_____

Are any children deceased? ☐ Yes ☐ No IF YES—when and how did this occur?

_____

_____

Any others who live with you? _____

_____

PEER RELATIONS

How do you consider yourself socially?

☐ Outgoing ☐ Shy ☐ Depends on the situation ☐ Other: _____

Are you happy with the amount of friends you have? ☐ Yes ☐ No | IF NO—please explain:

_____

Are you happy with your choice of friends? ☐ Yes ☐ No | IF NO—please explain:

Are you involved in any organized social activities (e.g. sports, clubs, music)? ☐ Yes ☐ No

IF YES—please list: _____

Please describe your sexual orientation:

☐ Heterosexual / straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Questioning / not sure

Are you sexually active? ☐ Yes ☐ No | IF YES—how many partners have you had? _____

IF YES—is your current sexual partner(s) (check all that apply):

☐ Male ☐ Female ☐ Transgender: Male-To-Female ☐ Transgender: Female-To-Male ☐ NONE

Do you use protections: ☐ Yes ☐ No

Have you ever had a STD? ☐ Yes ☐ No | IF YES—please explain: _____

If female, have you ever been pregnant? ☐ Yes ☐ No | IF YES—how many pregnancies? _____

IF YES—what was the outcome of each pregnancy? _____

Have you ever exchanged sex for money, food, shelter or drugs? ☐ Yes ☐ No

IF YES—please explain: _____

Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger? ☐ Yes ☐ No | IF YES—please explain:

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual) Please describe as much as you feel comfortable:

Have you ever been bullied or taken advantage of by someone? ☐ Yes ☐ No

IF YES—please explain: _____

Are you currently being hurt by someone you are close to or involved with? ☐ Yes ☐ No

IF YES—please explain: _____

Do you feel safe at home? ☐ Yes ☐ No | IF NO—please explain: _____

SPIRITUAL HISTORY

What spiritual tradition where you raised in, if any? _____

Do you currently practice a spiritual tradition? ☐ Yes ☐ No

IF YES—please describe: _____

How does your spirituality affect your life in general and/or daily life? _____

Are your spiritual beliefs: ☐ Helpful ☐ A Hindrance

Please explain: _____

_____

Will your spiritual beliefs be an important part of counseling? ☐ Yes ☐ No

Please explain: _____

_____

EDUCATIONAL HISTORY

What is your highest grade of education? _____

Please list your degree(s) / diploma(s) earned: _____

What was your overall feeling towards school when you were growing up? _____

_____

What were your grades like? _____

Did you like school? ☐ Yes ☐ No | Please explain: _____

_____

Did you attend regularly? ☐ Yes ☐ No | Please explain: _____

_____

Do you have a diagnosed learning disability? ☐ Yes ☐ No

IF YES—please describe: _____

_____

EMPLOYMENT HISTORY

Beginning with your most recent first, please list jobs or positions you have held (include seasons in the home)

_____

_____

_____

_____

_____

_____

Are you currently working? ☐ Yes ☐ No

How satisfied are you with your current employment situation?

☐ Unsatisfied ☐ Moderately Satisfied ☐ Very Satisfied

Please explain: _____

PRESENT LIFE

Please indicate your general mood level for the last month by **circling** one or more of the words below:

SUICIDAL DEPRESSED DOWN AVERAGE HAPPY ECSTATIC

Please indicate your current level of anxiety / nervousness over the last month by **circling** one or more of the words on the scale below:

PEACEFUL UNEASY WORRIED VERY ANXIOUS SEVERELY ANXIOUS

Please indicate all that apply for yourself currently.

- ☐ Threats of killing or hurting self
- ☐ Threats of killing someone else
- ☐ Acting without thinking
- ☐ Avoidance of responsibility
- ☐ Exaggerated sense of worth
- ☐ Exposure to traumatic event
- ☐ Frequent physical complaints
- ☐ Hard to remember things
- ☐ Hear or see things others do not
- ☐ Interrupting others frequently
- ☐ Mood goes up and down lot
- ☐ Not interested in things
- ☐ Over-tired or easily fatigued
- ☐ Pre-occupation with sex
- ☐ Prescription drug abuse
- ☐ Sad most of the time
- ☐ Shortness of Breath
- ☐ Strong sense of right and wrong
- ☐ Tics/other involuntary movements
- ☐ Unable to keep friends
- ☐ Any kind of reference to killing or hurting self
- ☐ Any kind of reference to killing someone else
- ☐ Angry mood
- ☐ Arrests
- ☐ Day wetting
- ☐ Delinquency
- ☐ Dieting
- ☐ Difficulty sleeping
- ☐ Domestic Violence
- ☐ Eating Problems
- ☐ Frequent conflict
- ☐ Hard to concentrate
- ☐ Hopelessness
- ☐ Lots of energy
- ☐ Muscle Tension
- ☐ Nightmares
- ☐ Recurring thoughts
- ☐ Soft Pornography
- ☐ Spiritual problem
- ☐ Abortion
- ☐ Bed wetting
- ☐ Body Image Issues
- ☐ Fearful
- ☐ Flash-backs
- ☐ Hard Pornography
- ☐ Helplessness
- ☐ Infidelity/Affair
- ☐ Irritable mood
- ☐ Night terrors
- ☐ Purging Food
- ☐ Secretive
- ☐ Self-injury
- ☐ Sexual difficulty
- ☐ Vandalism
- ☐ Weight problem
- ☐ Worry alot
- ☐ Argumentative
- ☐ Blames others
- ☐ Drug/alcohol abuse
- ☐ Extreme shyness
- ☐ Fire Setting
- ☐ Hair pulling
- ☐ Hurting animals
- ☐ Internet relationship(s)
- ☐ Lack confidence
- ☐ Lying
- ☐ Poor decisions
- ☐ Racing thoughts
- ☐ Repetitive Behaviors
- ☐ Stealing
- ☐ Tearful

PERSONAL STRENGTHS

What are your greatest accomplishments or things that make you feel successful? _____

Who and what are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? Please described:

Feel free to use the space below to explain or add anything further you would like us to know.

My signature below confirms that I have done my absolute best to answer the following questions honestly and completely.

PRINTED NAME

SIGNATURE

DATE