THE MAURIELLO GROUP

BEHAVIORAL HEALTHCARE | CONSULTATIVE SERVICES | IN-SERVICE TRAININGS

CLIENT HISTORY

CLIENT LEGAL NAME: ____ **DATE:** ________________

CLIENT PREFERRED NAME: ____________________________________

FAMILY & SOCIAL BACKGROUND

Please list and describe your current family members (immediate, extended, adopted, etc.) and/or other members of your current household.

NAME	RELATIONSHIP	AGE	OCCUPATION	COMMENT(S)
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			

Birthplace:_______________________________________

Were you adopted? ☐ YES ☐ NO If yes, what age? _________

Did your parents ever divorce? ☐ YES ☐ NO If yes, what age? _________

Were you ever in foster or residential care? ☐ YES ☐ NO If yes, what age? _________

Have you ever experienced a death of someone close? ☐ YES ☐ NO

*If yes, please describe:*____

____

____

Primary language at home as a child: ___________________________________

Primary language at home as an adult: _________________________________

CLIENT LEGAL NAME:______________________________________

Please describe your race, ethnicity, or national origin: ______________________________________

Please describe any relevant or important information regarding your ethnic or cultural background:

Do you have any specific problems/concerns related to your racial or ethnic background? ☐ YES ☐ NO

*If yes, please describe:*______________________________________

Religious or spiritual background: ______________________________________

Current religious or spiritual activity:______________________________________

Do you have any religious or spiritual concerns now? ______________________________________

Please list any recreational interests, activities, or hobbies: ______________________________________

Do you believe you spend enough time on your interests or non-work activity? ☐ YES ☐ NO

Please describe what you value most about yourself or what you believe are your greatest strengths: ______

EDUCATIONAL HISTORY

Please list all of the schools you are or have attended, starting with the current or most recent:

DATES ATTENDED	SCHOOL NAME	GRADES / GPA	GRADUATE?	ANY CONCERNS?

List any special training / skills: ______________________________________

List any plans to go to school: ______________________________________

List any learning disabilities: ______________________________________

List any speech/language problems: ______________________________________

List any educational concerns: ______________________________________

CLIENT LEGAL NAME:______________________________________

EMPLOYMENT HISTORY

Current Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:________________

Please list all of the jobs you have held, starting with the current or most recent:

DATES EMPLOYED	EMPLOYER	JOB TITLE	REASON FOR LEAVING

Are you looking for work or new job now? ☐ YES ☐ NO ☐ N/A

Do you have any employment problems now? ☐ YES ☐ NO ☐ N/A

If yes, please describe: ____

____

____

Have you ever been fired? ☐ YES ☐ NO ☐ N/A

If yes, please describe: ____

____

____

Do you have any military experience? ☐ YES ☐ NO ☐ N/A

Branch:____________________ Current/Highest Rank:____________________________

Discharge Date:______________ Type of Discharge:______________________________

LEGAL HISTORY

Please list and describe any current or past arrests, court appearances, or other legal concerns:

ARREST DATE	CHARGE	CONVICTED?	SENTENCE

Any prior incarceration dates? ☐ YES ☐ NO **If yes, describe:**________________________

Are you currently on Probation? ☐ YES ☐ NO **If yes, end date:**________________________

Are you currently on Parole? ☐ YES ☐ NO **If yes, end date:**________________________

Are you involved in any lawsuits? ☐ YES ☐ NO **If yes, describe:**________________________

Any upcoming court dates? ☐ YES ☐ NO **If yes, describe:**________________________

Are you currently involved in divorce proceedings? ☐ YES ☐ NO

Are you currently involved in custody proceedings? ☐ YES ☐ NO

CLIENT LEGAL NAME:______________________________________

*If yes to any above, describe outstanding legal concerns:*______________________________________

____
____
____
____
____

TRAUMA HISTORY:

Please indicate if you and/or other important person in your life either experienced or witnessed one or more of the following:

EXPERIENCE	SELF	OTHER	RELATIONSHIP	COMMENT(S)
Emotional Abuse				
Physical Abuse				
Sexual Abuse				
Domestic Violence				
Neglect				
Natural Disaster				
Serious Illness				
Accident / Injury				
Crime Victimization				
Financial Problems				
Military Combat				
Homelessness / Housing				
Discrimination				
School / Workplace Bullying				
Incarceration				

SEXUAL HISTORY

Are you currently sexually active? ☐ YES ☐ NO

Do you use safer sex practices to reduce risk of infection or pregnancy? ☐ YES ☐ NO ☐ N/A

How would you describe your sexual identity (e.g., male, female, intersex)?

____
____

How would you describe your gender identity (e.g., man, woman, gender non-conforming, etc.)?

____
____

How would you describe your sexual orientation (e.g., heterosexual, homosexual, bisexual, etc.)?

____
____

Describe any prior treatment for sexual concerns, including sexual desire, arousal, or orgasm.

____
____

Do you think your experiences regarding your sexuality are related to your current concerns or difficulties?

____
____

CLIENT LEGAL NAME:____

PERSONALITY TRAITS

These questions are about how you usually behave, think, and feel; in other words your overall way of being most of the time and in most situations. Read each question carefully, and answer each question by a single response.

1. In general, do you have difficulty making and keeping friends? ☐ YES ☐ NO
If "yes," does this apply to you most of the time and in most situations? ☐ YES ☐ NO

2. Would you normally describe yourself as a loner? ☐ YES ☐ NO
If "yes," does this apply to you most of the time and in most situations? ☐ YES ☐ NO

3. In general, do you trust other people? ☐ YES ☐ NO
If "no," does this apply to you most of the time and in most situations? ☐ YES ☐ NO

4. Do you normally lose your temper easily? ☐ YES ☐ NO
If "yes," does this apply to you most of the time and in most situations? ☐ YES ☐ NO

5. Are you normally an impulsive sort of person? ☐ YES ☐ NO
If "yes," does this apply to you most of the time and in most situations? ☐ YES ☐ NO

6. Are you normally a worrier? ☐ YES ☐ NO
If "yes," does this apply most of the time and in most situations? ☐ YES ☐ NO

7. In general, do you depend on others a lot? ☐ YES ☐ NO
If "yes," does this apply most of the time and in most situations? ☐ YES ☐ NO

8. In general, are you a perfectionist? ☐ YES ☐ NO
If "yes," does this apply most of the time and in most situations? ☐ YES ☐ NO

MENTAL HEALTH & PHYSICAL HEALTH TREATMENT HISTORY:

Have you ever been HOSPITALIZED in a psychiatric hospital? ☐ YES ☐ NO

DATES OF ADMISSION	HOSPITAL	REASON FOR ADMISSION

Have you ever received any prior OUTPATIENT counseling or psychotherapy? ☐ YES ☐ NO

DATES OF TREATMENT	LOCATION / AGENCY	REASON FOR TREATMENT

CLIENT LEGAL NAME:____

Have you ever been involved in any SELF-HELP or SUPPORT groups? ☐ YES ☐ NO
(e.g., Alcoholics Anonymous or other 12-step groups, Weight Watchers, etc.)

DATES OF INVOLVEMENT	GROUP	REASON FOR INVOLVEMENT

Please list any current MEDICATIONS, including psychiatric medications:

NAME OF MEDICATION	PRESCRIBER	REASON PRESCRIBED

Did you previously take any previous psychiatric medications at any time? ☐ YES ☐ NO
If yes, please describe what and when: ____
____

Please check any of the following concerns that apply to you now or within the past:

☐ Depression
☐ Mood swings
☐ Hopelessness
☐ Guilt/shame
☐ Loneliness
☐ Loss of appetite
☐ Overeating/bingeing
☐ Sleep disturbance
☐ Nightmares
☐ Thoughts of harming self
☐ Thoughts of harming others
☐ Suicide attempts/injuries
☐ Cutting
☐ Hearing voices
☐ Seeing things others do not
☐ Unusual thoughts
☐ Increased alcohol use
☐ Increased drug usage
☐ Blackouts/memory loss
☐ Withdrawal symptoms
☐ Financial worries
☐ Overspending
☐ Gambling
☐ Poor impulse control
☐ Poor anger control
☐ Yelling at others
☐ Hitting others
☐ Breaking objects
☐ Feeling controlled
☐ Feeling suspicious
☐ Pessimism
☐ Phobias/Fears
☐ Nervous/Anxious
☐ Panic attacks
☐ Poor concentration
☐ Confusion
☐ Disorganized
☐ Racing thoughts
☐ Fear of dying
☐ Job stress
☐ Decreased activity
☐ Not seeing friends
☐ School problems
☐ Sexual problems
☐ Obsessions/Compulsions
☐ Marital/Couple concerns
☐ Parenting concerns
☐ Traumatic Brain Injury

Please explain any checked items: ____
____
____

Have you ever attempted to commit SUICIDE or engaged in serious self-harm? ☐ YES ☐ NO
If yes: How many times? ____________ Dates? ____
Method(s) of Attempt(s):____

CLIENT LEGAL NAME:______________________________________

Has anyone in your family attempted suicide? ☐ YES ☐ NO If yes, who? ____________________

Has anyone in your family committed suicide? ☐ YES ☐ NO If yes, who? ____________________

Do you have any current medical problems? ☐ YES ☐ NO

*If yes, please list and describe below:*______________________________________

Do you have any history of major medical interventions or surgery? ☐ YES ☐ NO

*If yes, please list and describe:*______________________________________

Do you have any history of head injury or traumatic brain injury? ☐ YES ☐ NO

*If yes, please list when and how:*______________________________________

Do you have any history of loss of consciousness? ☐ YES ☐ NO

*If yes, please list when and how:*______________________________________

ALCOHOL AND DRUG HISTORY

Please list and describe any substance abuse and/or substance treatment history.

During the last 12 months…

- **Did you ever experience blackouts (i.e., memory lapses) when drinking?** ☐ YES ☐ NO
- **Did you ever drink more than you planned to drink?** ☐ YES ☐ NO
- **Did you use larger amounts of substances or use them for a longer time than you planned or intended?** ☐ YES ☐ NO
- **Did you try to cut down on your substance use, but were unable to do it?** ☐ YES ☐ NO
- **Did you spend a lot of time getting substances, using them, or recovering from their use?** ☐ YES ☐ NO
- **Did you get so high or sick from using substances that it kept you from doing work, going to school, or caring for children?** ☐ YES ☐ NO
- **Did you get so high or sick from substances that it caused an accident or put you or others in danger?** ☐ YES ☐ NO
- **Did you spend less time at work, school, or with friends so that you could use substances?** ☐ YES ☐ NO
- **Did your substance use cause emotional or psychological problems?** ☐ YES ☐ NO
- **Did your substance use cause problems with family, friends, work, or police?** ☐ YES ☐ NO
- **Did your substance use cause physical health or medical problems?** ☐ YES ☐ NO
- **Did you increase the amount of a substance so that you could get the same effect?** ☐ YES ☐ NO

CLIENT LEGAL NAME:____

Did you ever keep using a substance to avoid withdrawal symptoms or keep from getting sick? ☐ YES ☐ NO

Did you get sick or have withdrawal symptoms when you quit or missed taking a substance? ☐ YES ☐ NO

Have you ever experienced an overdose? ☐ YES ☐ NO

Has anyone ever commented or been concerned about your drinking or drug use? ☐ YES ☐ NO

Has drinking or drug use ever caused problems in any of the following areas?

☐ Family ☐ Employment ☐ Legal ☐ Emotional
☐ Social ☐ Financial ☐ Behavior ☐ Physical

Please complete the following chart regarding any substance use in the past 12 months:

TYPE OF DRUG	Check how often you used each drug in the past 12 months?					Age of 1st use	Describe your peak use for each drug		Date of Last Use
	Never	<1x per month	1-3x per month	1-5x week	>6x per week		When?	How much?	
Caffeine									
Nicotine/Tobacco									
Alcohol									
Marijuana									
Cocaine (powder)									
Cocaine (crack)									
Heroin / Opiates									
Methadone									
Suboxone									
Opioids / Pain Meds									
Ecstasy / MDMA									
Muscle Relaxers									
Anti-anxiety meds									
Inhalants									
PCP									
LSD									
(Meth)amphetamine									
Sleeping pills									
Diet Pills									
Steroids									
Other:									

Have you ever received any INPATIENT alcohol/drug treatment? ☐ YES ☐ NO

If yes, where/when: ____
____
____

CLIENT LEGAL NAME:______________________________________

Have you ever received any OUTPATIENT alcohol/drug treatment? ☐ YES ☐ NO

If yes, where/when: ____

____

____

Has any family member or loved one ever had a drinking or drug problem? ☐ YES ☐ NO

If yes, please describe who / what problem(s): ______________________________________

____

____

When was the longest period you were able to remain in recovery from substances, and how long was it?

____

____

What contributes or would contribute to you relapsing on substances?

____

____

____

List any other relevant information that you believe is important to your treatment:____________________

____

____

____

____

____

____

____

I verify the above information is true and complete to the best of my knowledge. I understand that any withholding of information, omissions, or misinformation may affect the course of or my response to any assessment(s) and/or treatment(s). I agree to inform my healthcare provider(s) of any relevant and/or significant changes as they occur throughout my course of assessment and/or treatment.

____ ____________________

Client Signature **Date**

____ ____________________

Healthcare Provider Signature **Date**