# Denise Lang-Grant, Ed.S., LPC

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Name: ________________________________ Date :_______________________

Address: ____________________________________________________________

Phone: ________________(h) ______________ (w) ___________________(Cell)

Email: _____________________________________________________

Age: _______ DOB: ____________ Male/Female (Circle One)

Emergency Contact Name: _______________________________

Phone: _____________Relationship to Client: _____________________________

Client Lives With (spouse/children/parents): _______________________________

Referred by: _______________________________Phone: __________________

**1. Presenting Problems:**

Chief Complaints (What do you see as a problem needing help?):

Suicidal ideation/ homicidal ideation depression anxiety compulsions obsessions psychosis eating disorder self-mutilation recent loss physical or sexual abuse relationship problems addictions sleep disturbances flashbacks

Explain:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Have you ever been in counseling before? Yes No For this issue or other? If Yes, please explain:

___________________________________________________________________

Previous Therapist/Psychiatrist:

______________________________________________________________

Have you ever been admitted to a hospital or outpatient facility for psychiatric

treatment? If yes, please explain: ______________________________________

_______________________________________________________________

Are you currently taking any medications? Please list:

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Do you have any medical problems for which you are being treated at the present time?

If yes, please explain: _______________________________________________

**2. <u>Social Environment:</u>**

Marital Status:
____ Single (never married)
____ Married……for_______
____ In a partnership…for _______
____ Living together…for ______
____ Engaged…for ________
____Divorced…..for _______
____ Widow/ed…for _________
____ Separated…for _______

How would you rate the quality of your current/past relationship on a scale of 0-10, with 0 being very destructive/abusive and 10 being very supportive and healthy?

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Who would you consider your Support System?
________________________________________________________________

________________________________________________________________

What is your religious/spiritual affiliation? Does it influence your life?
_______________________________________________________________

________________________________________________________________

## 3. Family of Origin:

Do you have any brothers or sisters? If yes, what are their ages and where do they live?

_______________________________________________________________________

Are your parents still living? Where do they live?

_______________________________________________________________________

How would you rate your relationship with them, on a scale of 1-10, with one being

“estranged” and 10 being “very close”? ______________________________________

Does anyone in your family have a history of: ___ mood disorders ___ suicide ___ anxiety disorders ___ psychosis ___ substance abuse?

If yes, please explain:

_______________________________________________________________________

_______________________________________________________________________

**4. Abuse History: (Childhood/Adolescence)**

Were you ever physically/ sexually abused as a child/adolescent?: ____ No ____ Yes

If yes, do you remember what age or how long it lasted?

_______________________________________________________________________

As a child/adolescent, were you ever emotionally/verbally/physically abused? If yes,

please explain: ________________________________________________________

Have you ever found yourself in the role of an abuser? If yes, please explain:

_______________________________________________________________________

**5. Education-Employment-Legal:**

What is the highest level of education you achieved?

_______________________________________________________________________

Are you currently employed? If yes, what type of work do you do?  If no, please explain:

_______________________________________________________________________

Have you ever served in the Military? If yes, please explain:
_______________________________________________________________________

Have you ever been arrested? If yes, please explain: ___________________________

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## 6. SUBSTANCE USE HISTORY

Please check the following, if they apply, and approximate frequency of use:

Alcohol _____________________________________________________

Marijuana ___________________________________________________

Cocaine ____________________________________________________

Heroin _____________________________________________________

Prescription Drugs:____________________________________________

Others _____________________________________________________

Do you see substance abuse as a problem?     ____ No   ____ Yes

If yes, please explain:

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Does your family see substance abuse as a problem of yours?

_______________________________________________________________________

Have you ever been hospitalized for substance abuse rehabilitation? If yes, when and where?

_______________________________________________________________________