Jamie Pedersen
Licensed Professional Clinical Counselor (CA LPC23)

Personal History

Name(s): _____

Issues of Concern

What issues/concerns caused you to seek counseling? _____

_____

_____

What are you specific goals with regard to your counseling? _____

_____

_____

Counseling History

Have you ever sought counseling before? Yes No If yes, when and for how long? _____

_____

What was the focus of counseling? _____

_____

Have you been hospitalized for mental or emotional problems? Yes No If yes, when and for how long?

_____

Have you ever attempted suicide? Yes No If yes, when? _____

Described the circumstances that lead to that attempt: _____

_____

_____

_____

Are you currently having any suicidal thoughts? Yes No If yes, please describe: _____

_____

_____

_____

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Medical History

Have you ever been diagnosed with a serious illness? Yes No

Circle if you have any of the following: Heart Condition Diabetes Cancer Tuberculosis Hepatitis Other

If yes, please describe: _____

_____

Do you have any medical conditions that may affect your mental health treatment? Yes No

If yes, please describe: _____

_____

_____

Are you physically active? Yes No Please describe: _____

_____

Do you have any allergies to medication? Yes No If yes, please describe: _____

_____

What medications are you taking?

Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition?

Yes No If yes, please describe: _____

_____

_____

_____

Have you ever been in a recovery/rehab program? Yes No If yes, please describe: _____

_____

_____

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Family History

Mother's Name: _____ Circle: Living Deceased

Describe relationship with mother: _____

_____

_____

_____

_____

Father's Name: _____ Circle: Living Deceased

Describe relationship with father: _____

_____

_____

_____

_____

Names and ages of brothers and sisters (including half and step):

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Were you ever subjected to verbal, physical, emotional, or sexual abuse? Yes No Not sure

If yes, please describe: _____

_____

_____

_____

Have you ever been a victim of a violent crime? Yes No

If yes, please describe: _____

_____

_____

_____

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Other Information

Please describe you spiritual identity/orientation (optional): _____

_____

_____

_____

Please describe your interests/hobbies: _____

_____

_____

_____

Are you involved in any legal action or a lawsuit, which will affect your therapy? Yes No

If yes, please describe: _____

_____

_____

Please feel free to include any other information that you believe is relevant to your counseling:

_____

_____

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