Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA
Counseling and Psychotherapy
7000 Houston Road, Building 200, Suite 15
Florence, KY 41042
859-816-4998

Date_____ Date of Birth:_____ Age:___

Name_____

What brought you to seek counseling?_____

How long has this been an issue?_____

What have you tried to do to resolve this issue?_____

What are your goals for counseling?_____

Previous Treatment History

Have you ever received psychiatric or psychological help or counseling of any kind before?

☐ Yes ☐ No

If yes, please explain and include outpatient counseling services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use._____

Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain.

Medical History

Describe your general health as well as any chronic conditions including pain.

Who is your primary care physician?

When was your last complete physical exam by an M.D. / D.O.?

Are you currently under the care of an M.D./D.O. for any condition? ☐ Yes ☐ No

If so, please explain and list any major health problems for which you currently receive treatment.

Please list all current prescription and over the counter medications you are now taking:

Name of Medication:	Dosage:	Date Started:

Please list prior medication for mental health issues, alcohol use, or chemical dependency:

Name of Medication:	Dosage:	Date Started:

Health Concerns

Please check any of the following that apply:

- ☐ Significant weight gain/loss in the last six months
- ☐ Food/drug allergies
- ☐ problems chewing or swallowing
- ☐ Dieting
- ☐ Overeating or eating too little

If any box is checked, please explain:_____

_____

_____

Do you have any functional limitations that affect your daily living, such as physical impairments, problems with self care, speech, vision or hearing? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

_____

Legal / Financial History

Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past:

DUI_____ Bankruptcy_____ Divorce_____
Unemployment_____ Domestic Violence_____ Custody Dispute_____
Disability Claim_____ Workman's Compensation_____

Please describe any current or previous financial problems:_____

_____

_____

Education and Employment History

Educational Background:

Highest Level Completed_____
Name of High School_____
Name of College/University Attended_____
Course of Study_____

Employment History:

Current Employer_____
Job Title_____
Please briefly describe current job_____

_____

_____

_____

Please describe history of military service_____

_____

_____

_____

History of Abuse

Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past:

Verbal Abuse_____ Emotional Abuse_____ Child Abuse_____
Physical Abuse_____ Spouse Abuse_____ Elder Abuse_____
Sexual Abuse_____

Alcohol and Drug Use History

Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____
When was the last time you had a drink?_____
How much did you drink at that time?_____
Do you have any history of using or abusing drugs/medications? ☐ Yes ☐ No
Do you currently abuse any drugs/medication? ☐ Yes ☐ No

What substances have you used in the last six months? (check all that apply)

☐ Marijuana/Pot	☐ Cocaine	☐ Inhalants/"Huffing"
☐ LSD/"Acid"	☐ Amphetamines/"Speed"	☐ Other
☐ Pain Killers	☐ Sedatives/"Downers"	☐ None of the Above

If "Other" is checked, please explain:_____

Check any of the following that has occurred as a result of your drinking or drug use:

☐ Arrest	☐ DUI	☐ Family Problems
☐ Public Intoxication	☐ Financial Problems	☐ Arguments
☐ Work Problems	☐ Health Problems	☐ Relationship Problems

Do you use Nicotene? ☐ Yes ☐ No Amount?_____
Do you use Caffeine? ☐ Yes ☐ No Amount?_____

Personal History

Sexual/Affectionate History:
Are you satisfied with your sex life? ☐ Yes ☐ No
Do you have any concerns or questions about your sexual orientation or experiences?_____

Religious/Spiritual History:
Do you have an identified religious preference?_____

History of Harm to Self or Others:
Do you currently have any urges/thoughts of hurting yourself? ☐ Yes ☐ No
Any current urges/thoughts of hurting another? ☐ Yes ☐ No
Any history of hurting self or suicide attempt? ☐ Yes ☐ No
Any history of physical aggression toward another? ☐ Yes ☐ No

If yes is checked, please explain:_____