Blue Sky Counseling

1301 Oregon Ave.
Alamogordo, NM 88310
Phone: (575) 443-6166
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Date: _____

Name: _____ Age: _____ DOB: _____

Race/Ethnicity: _____ Phone: _____

Address: _____

How do you get to the places you need to be? _____

_____

How would you describe yourself? _____

_____

_____

_____

What are your hobbies or special interests? _____

_____

_____

Why have you come to counseling? _____

_____

What are the major stressors in your life? _____

_____

How do you cope with stressful situations? _____

_____

Symptoms: (Circle all the symptoms that you have experienced in the last month.)

Sleeplessness Lack of Motivation/Interest Difficulty Concentrating Irritability Change in Appetite Feelings of Guilt Impulsiveness Loss of Sex Drive

Periods of high energy Periods of low energy Racing thoughts Headaches

Dizziness Heart Pounding Muscle Spasms Constipation

Muscle Tension Diarrhea Changes in Vision Numbness Tic/Twitches

Fatigue Fainting Blackouts Chest Pain Skin Problems Nausea

Dry Mouth Chocking Sensations Chills/Hot Flashes Trembling/Shaking

Rapid Heart Beat Sweating Shortness of Breath

How often do you experience these symptoms? _____

When did you first start experiencing these symptoms? _____

Are there times when you are more likely to experience some symptoms? Yes/No
If yes, please explain: _____
_____
_____

Mood: (Describe your mood over the past two weeks. Circle all that apply.)

Calm Sad Anxious Angry Frustrated Up and Down Worried

Hopeless Helpless Euphoric Other_____

How often do you feel this way? _____

When did you first start feeling this way? _____

How would you rate your self-esteem (1 -10 scale)? _____

Mental Health History: (Circle Yes or No)

1. Have you ever had contact with a mental health professional before today? Yes/No
   If yes, describe when and the circumstances: _____
   _____
   _____
2. Have you ever been hospitalized or placed in a Residential Treatment Center any reason? Yes/No
   If yes, describe when and the circumstances: _____
   _____
   _____
3. Have you ever been diagnosed with a mental health disorder? Yes/No
   If yes, give the diagnosis and who diagnosed you: _____
   _____
   _____
4. Has there been a member of your family with mental health problems? Yes/No
   If yes, describe your relationship to them and the nature of the problem: _____
   _____
   _____
5. Do you experience mood swings? Yes/No
   If yes, describe the circumstances: _____
   _____
   _____
6. Does life seem to be one crisis after another? Yes/No
   If yes, give an example: _____
   _____
   _____
7. Do you ever secretly cry, cut, or hurt yourself to feel better? Yes/No
   If yes, describe the circumstances: _____
   _____
   _____
8. Are you currently having thoughts of hurting or killing yourself or someone else? Yes/No
   If yes, do you have a plan? Yes/No
   If yes, describe your plan: _____
   _____
   _____
9. In the past, have you ever had thoughts of killing or hurting yourself? Yes/No
   If yes, when was the last time you thought of it? _____
10. In the past, have you ever made an attempt to kill or hurt yourself? Yes/No

If yes, describe the attempt and when it occurred: _____

_____

_____

11. Do you hear voices or see things when nothing is there? Yes/No
    If yes, describe the circumstances: _____

    _____

    _____

12. Are you currently taking any psychiatric medications? Yes/No (Please list below)

Medication	Purpose	Effective? (Yes or No)
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Medical History: (Circle Yes or No)

1. Do you have any illnesses or medical problems? Yes/No
   If yes, please describe: _____

   _____

   _____

2. Ever experienced head trauma or been involved in a major accident? Yes/No
   If yes, please describe the circumstances and the nature of your injuries: _____

   _____

   _____

   _____

3. If prescribed, would you be willing to take medications designed to improve your mental health? Yes/No
   If no, please explain why not: _____

   _____

   _____

4. Please list any medication you take, and if prescribed, who prescribes them for you.

Medication	Purpose	Prescribed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you allergic to any medications? Yes/No
   If yes, please list: _____

   _____

6. Have you ever been hospitalized overnight? Yes/No

If yes, describe the circumstances: _____

_____

_____

7. Do you exercise? Yes/No
   If yes, describe what type of exercise(s) and how frequently you do it? _____

   _____

   _____

Substance History: (Circle Yes or No)

1. Do you use tobacco? Yes/No
   If yes, what form(s) of tobacco do you use? _____
   How much and how often do you use it? _____
   How old were you when you first used it? _____

2. Do you use caffeine? Yes/No
   If yes, what form(s) of caffeine do you use? _____
   How much and how often do you use it? _____

3. Do you use alcohol? Yes/No
   If yes, what do you drink? _____
   Have you or anyone else ever been concerned about your drinking? Yes/No
   How much and how often do you use it? _____
   How old were you when you first used it? _____

4. Do you use recreational drugs, inhalants, or take medications (prescribed or over-the-counter) other than as recommended? Yes/No
   If yes, please list:

Drug/Medication	Age at 1st Use	Age at Last Use	Frequency of Use

5. Does or has anyone in your family abuse alcohol, drugs, or medications? Yes/No
   If yes, please describe your relationship to them: _____

   _____

6. Has anyone you know been arrested or put in jail or prison because of alcohol or drugs? Yes/No
   If yes, please describe: _____

   _____

   _____

7. Do many of your close acquaintances use or abuse alcohol or drugs? Yes/No

8. Do you gamble? Yes/No How frequently? _____

Social History:

1. Where did you grow up? _____
2. Are your parents married, separated, or divorced? _____ # of Times? _____
   If your biological parents are not still married, how old were you when they separated or divorced? _____
3. Who raised you? _____
4. Please list your brothers and sisters from oldest to youngest, include yourself.

Name	Current Age

5. Describe your childhood? _____
   _____
6. Do you have any memories of being abused as a child (physical/sexual/verbal)? Yes/No
   If yes, please describe: _____
   _____
   _____
7. What is your best memory as a child? _____
   _____
8. Describe your adolescence? _____
   _____
9. Was there violence in your home growing up? Yes/No
   If yes, please describe: _____
   _____
   _____
10. What is your best memory as a teen? _____
    _____

11. Are you sexually active? Yes/No

12. How would you describe your relationship with your current or most recent partner? _____
_____
_____
_____

13. What do you like best and least about that relationship? _____
_____
_____
_____

14. Do you have or are you expecting children? Yes/No
If yes, please list from oldest to youngest:

Name	Current Age	Live with you?
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

15. Are you currently married? Yes/No
If yes, for how long? _____ Number of prior marriages? _____

16. With whom do you currently live? _____
_____

17. Do you get enough support from family and friends? Yes/No

18. To whom do you go when you have problems? _____
_____

Educational History:

1. What school(s) did/do you attend? _____
_____

2. Were you held back or did you fail a grade? _____

3. Any Learning Disabilities? Yes/No
If yes, please describe: _____
_____

4. Did you receive Special Education Services? Yes/No

5. What kind of grades did you receive? _____

6. Were you involved in extracurricular activities? Yes/No
If yes, please describe: _____

7. In high school, would you say you were popular, a loner, or had a few friends? _____
_____

8. Did you get involved in many fights? Yes/No

9. Do you have difficulty concentrating or focusing on a topic for more than a short time? Yes/No

10. Is it hard for you to sit quietly without fidgeting? Yes/No

11. Do you have a high school diploma or GED? Yes/No

12. What is the highest grade you have completed? _____

13. What is your educational goal? _____

Work History:

1. Are you currently employed? Yes/No
   If yes, where? _____ How long? _____
   What do you do? _____

2. Are you satisfied with your current employment? Yes/No

3. How many jobs have you held in the past? _____

4. How many have you been fired from? _____

5. How many have you quit without giving notice? _____

6. Are you/your family currently receiving any form of public assistance? Yes/No
   If yes, what type? _____ For how long? _____

7. Are you/your family currently experiencing any unusual financial hardships? Yes/No
   If yes, please describe: _____
   _____
   _____

Legal History:

1. Have you ever been referred/arrested for committing a crime or delinquent act?
   Yes/No If yes, how many times? _____

2. Have you ever been in detention, jail, or prison? Yes/No
   If yes, how many times? _____ Please describe the circumstances: _____
   _____
   _____
   _____

3. Have you ever been on probation? Yes/No
   If yes, how many times? _____
   Currently? Yes/No If yes, date you will complete probation: _____
   Please describe the circumstances: _____

4. Has a member of your family or a close friend ever been arrested, jailed, or been in prison?
   If yes, how many times? _____ Please describe the circumstances: _____

Other:

1. Provide any other information you wish us to know about you. _____

2. List three goals you would like to achieve through counseling.

   Goal #1: _____

   Goal #2: _____

   Goal #3: _____