Charu Chandra, LCPC
1142 Chicago Ave. Suite 2 E, Oak Park, IL 60302, 700 N. Sacramento Ste. 200, Chicago, IL 60612
(312) 479-4779

Client Information

Name _____ Date _____

DOB _____ Age: _____ Gender: ☐Male ☐Female Soc. Sec. # _____

Address _____ Apt. _____ City _____

State _____ Zip _____

Employer/School _____ Occupation/Studying _____

Home Phone _____ May we leave a message? ☐Yes ☐No

Work Phone _____ May we leave a message? ☐Yes ☐No

Family Information

Relationship Status: Single _____ Married _____ Partnered _____ Divorced _____ Widow/Widower

Number of children and their ages:

_____
_____
_____
_____

Were your parents: divorced _____ never married _____ still married _____ widowed

_____

Where are you in the birth order of siblings in your family? _____

Emergency contact person (name, relationship, phone, address).

_____
_____

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name Birth Date Relationship Living with you?

_____
_____
_____
_____

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Family Mental health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Members_
• Alcohol/Substance Abuse	yes/no	
• Anxiety	yes/no	
• Depression	yes/no	
• Domestic Violence	yes/no	
• Eating Disorders	yes/no	
• Obesity	yes/no	
• Obsessive Compulsive Behavior	yes/no	
• Schizophrenia	yes/no	
• Suicide Attempts	yes/no	
• Sexual Abuse	yes/no	
• Emotional Abuse	yes/no	
• Mental Illness	yes/no	

Please explain any chronic illness_____

Other_____

Medical Information

Primary Physician_____Phone: _____Date Last Exam _____

Major or Chronic Illnesses/Injuries

_____

Operations

_____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have you experienced any recent changes in any of the following areas?

Sleep Behaviors / Amount of Exercise / Sexual Desire / Eating /Appetite /Weight

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Substance Use

Tobacco: Do you smoke? Yes_____ No_____

Smoked in the past? Yes_____ No_____

If yes- cigarettes/Day _____ Began at what age? _____

If no longer smokes- When did you quit? _____

Alcohol: Do you consume alcohol? Yes _____ No _____

If so, how much: Less than 1x/month _____ 1a3x month _____1x week _____

Several x's a week _____ Everyday__

check all that apply: Beer _____ Wine _____ Hard Liquor _____

Drugs: Do you use any street drugs or misuse prescription drugs? Yes _____ No _____

If yes, list as follows:

Name of Drug	Frequency of use

Counseling Information

Please describe the main concerns that prompted you to seek services at this time?

_____

_____

_____

How have these concerns evolved over time?

_____

_____

_____

Please indicate what major stressors you have had in the last 12 months

Serious illness or injury, Death of a close Friend or Family Member, Job change,

Major Illness in Family, Gain of New Family Member, Divorce/Separation, Other

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What you would like to be different for you when therapy ends?

_____

_____

Have you ever received psychological or psychiatric counseling before? Yes _____ No _____

If so, please describe when, from whom, purpose and the results

_____

_____

Have you ever been prescribed medication for psychiatric or emotional problem/s? Yes __No__

If so, please describe when, prescribing clinician, what medication, for what, and the results

_____

_____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes _____ No __
If so, please describe when, where, for what reason, result

_____

_____

Have you been in a drug or alcohol program? Yes ____ No ____ If yes, how many times _____
If so: When _____ Inpatient _____ Outpatient _____How Long _____
Outcome_____

_____

Please indicate if you have experienced any current or past issues in the following areas:

Physical, Sexual or Emotional Abuse _____

_____

Harming self _____

_____

Violent behaviors_____

_____

Legal Problems _____

_____

Suicidal thoughts or behaviors _____

_____

Witnessing domestic violence _____

_____

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Please list the first names of your significant friends and indicate how long you have had these relationships

First Name	How Long	How often do you see this person

Spiritual Resources

Do you consider yourself to be spiritual or religious? □No □Yes

If yes, describe your faith or belief:_____

_____

What do you consider to be some of your strengths?_____

_____

_____

What do you consider to be some of your weakness? _____

_____

_____

Other

Is there anything else you think I should know about prior to beginning counseling?

_____
_____
_____
_____
_____
_____

Thank you for your time. I look forward to working with you.

Client Signature_____

Counselor Signature_____ _____