Metamorphosis Counseling Services

6601 Memorial Highway, Suite 108
Tampa, FL 33615
(813) 407-9550

CLIENT HISTORY AND INFORMATION

Basic Information:

Patient Name:	**Date:**
Last 4 digits of your Security Number:	**Date of Birth:**
Ethnicity:	**Gender Identity: [ ] Male [ ] Female** **Sexual Orientation Identity:**
Home Address:	**Email Address:**

Mobile Phone Number _____ May we leave a message? [ ] Yes [ ] No	**Work Phone Number** _____ May we leave a message? [ ] Yes [ ] No	**Home Phone Number** _____ May we leave a message? [ ] Yes [ ] No

Which best describes your marital status? [ ] Married, Date: _____ [ ] Never Married [ ] Widowed, Date: _____	[ ] Separated, Date: _____ [ ] Divorced, Date:_____

History Information

Who is providing the history information?: [ ] The patient [ ] The patient's guardian [ ] Other: _____

Please describe the current complaint or problem as specifically as you can, in your own words:

_____
_____
_____
_____
_____
_____
_____
_____

How long have you experienced this problem, or when did you first notice it?:
_____

What stressors may have contributed to the current complaint or problem?:
_____

Previous Treatment

Have you received or participated in previous counseling and/or therapy?: [ ] Yes [ ] No

If so, what did you like/dislike about previous treatment?:

_____

Have you had hospital stays for psychological concerns?: [ ] Yes [ ] No. If yes, please explain:
_____
_____
_____

Are you currently experiencing thoughts of harming either yourself or someone else?: [ ] Yes [ ] No. If yes, please explain:
_____
_____
_____

Have you in the past experienced thoughts of harming either yourself or someone else?: [ ] Yes [ ] No. f yes, please explain:
_____
_____
_____

Are you currently experiencing visual, auditory or sensory hallucinations?: [ ] Yes [ ] No. If yes, please explain:
_____
_____
_____

Developmental History

Are you satisfied at where you are in your life?: [ ] Yes [ ] No

If not, where would you like to be? _____

_____

Medical History

List any current or important past medications:

Medication	Dosage	Any side effects?:

History of serious childhood illnesses:

_____

How would you rate your current physical health?

[ ] Excellent [ ] Good [ ] Poor
[ ] Very Good [ ] Fair [ ] Very Poor

Family History

Birth Location: _____ Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father
[ ] Other: _____

How would you describe your relationship with parent figures (good, fair, poor, close, distant, etc.):
Mother: _____ Step-parent: _____
Father: _____ Other:_____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?: [ ] Yes [ ] No

If yes, please explain: _____

Any family history of substance abuse, mental illness, suicide, or violence?: [ ] Yes [ ] No

If yes, please explain: _____

Any Additional Family Information: _____

Social History

Describe your relationship with peers and/or friends?: _____

How would you describe your social support network?: _____

Describe your hobbies/interests: _____

Describe any cultural concerns: _____

Occupational History

What is your current employment status?

[ ] Employed Full-Time	[ ] Unemployed	[ ] Student
[ ] Employed Part-time	[ ] Self-employed	[ ] Other

Are you satisfied with your employment?: [ ] Yes [ ] No

If not, why?: _____

Referral Source

Who referred you to our office, or how did your learn about our practice?: _____

Contact Information

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Summarize your goals for counseling/therapy:

_____

_____

What expectations do you have for counseling/therapy?: _____

Name 3 things you would like to change about yourself: _____

_____

What do you consider your strengths to be?: _____

What do you consider your weaknesses to be?: _____

Is there any additional information that you believe is important for your counselor to know in order to provide you with the best care possible?:

_____

_____

_____

_____	_____	_____
Printed Name of Client	Signature of Client	Date

_____	_____	_____
Printed Name of Guardian	Signature of guardian	Date