Kevin Lemieux Counseling Services
Kevin Lemieux LPC
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541-687-9674

Client Information

Name: _____ Age: _____

Address: _____

Phone Number: _____ Cell Phone: _____

Physician or Primary Care Provider -

Name: _____ Physician's Phone Number: _____

Reasons for seeking counseling:

Have you sought counseling in the past? Yes No

Are you currently in treatment with a counselor or therapist? Yes No

If you have received counseling, or are currently in treatment, please list when, the approximated age(s) you were at the time, and length of time in counseling.

Please check any of the following that describes your family and home atmosphere when you were a child:

☐ Alcoholism ☐ Democratic ☐ No fun

☐ Affectionate	☐ Distant	☐ Overprotective
☐ Angry	☐ Frightening	☐ Physical abuse
☐ Close	☐ Mental illness	☐ Sexual abuse
☐ Cold	☐ Excessive moving	☐ Physical illness
☐ Competitive	☐ Neglectful	☐ Poverty
☐ Prejudice	☐ Rigid	☐ Spiritual abuse
☐ Stable	☐ Supportive	☐ Trusting
☐ Verbal abuse	☐ Fighting	☐

Other:_____

Social Experience

Are you satisfied with your current social life? (Briefly explain)

Please describe any organized or informal social groups that you are actively involved in.

Marital History

Are you currently married or have a domestic partner? Yes No

If yes, how long have you been married or in this relationship?

Have you been divorced/dissolved partnership? Yes No

How long did the relationship last?

Educational History

What was the last grade (or degree) which you completed? (Include approximate dates)

Please list any certificates, licenses or specific training that you have earned. (Include approximate dates)

How did you do academically in school?

Grade school:

Middle School:

High School:

College:

How did you do socially in school (e.g. friends, activities, clubs, dating and interactions with teachers)?

Have you ever been tested for a learning disability?

Military History

Have you ever served in the armed forces? Yes No

If yes, which branch did you serve in?

How long did you serve in the military?

Did you experience combat while in the military? Yes No

Are you service connected? Yes No

Legal History

Have you ever had any legal difficulties? Yes No
(Briefly explain)

Medical History

When was your last physical examination?

Please list any significant surgeries or procedures you have had, including approximate dates.

Please list any significant accidents or injuries you have had, including approximate dates.

Please describe any head injuries, seizures or loss of consciousness you have had, including dates.

Are you currently taking medication? Yes No
If yes, please list medications and reasons for taking them.

Substance History

Family use: Does anyone one in your family (immediate or otherwise) have a history of drug or alcohol abuse? Yes No

Please describe the relationship you have with this person (mother, father, brother, etc.)

Do you have a history of drug or alcohol abuse? Yes No

Do you use nicotine? Yes No What form/how much?

Do you use caffeine? Yes No What form/how much?

Emotional/Mental Health History:

If you have participated in counseling before today, please explain how the experience was helpful or not helpful.

In the past, have you taken medication for mental health issues (e.g. depression, anxiety, mood swings)? If yes, please list the medication and dosages.

Have you been diagnosed with an emotional or mental illness? If yes, what was your diagnosis?

Are you currently taking medication for mental health issues? If yes, please name the medications and dosages.

Occupational History

Are you currently employed? Yes No

If employed, what is your current occupation? (Stay-at-home mom counts!!!)

How many hours a week do you work?

On a scale of 1 to 10 what is your job satisfaction? (Please circle one)

1 2 3 4 5 6 7 8 9 10
Dissatisfied Very Satisfied

Spiritual History

Please describe your family's spiritual or religious atmosphere while you were growing up.

Are you currently involved with any spiritual group or community?

Have you found your spiritual beliefs helpful or a hindrance?

Mood Scale

Please indicate your general mood level for the last month by circling one of the numbers on the scale below:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
Suicidal Thoughts Depressed Average Good Spirits Joyful

Now mark an "L" over one of the numbers to describe the low point of your mood during the last month.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Suicidal Thoughts Depressed Average Good Spirits Joyful

Anxiety Scale

Please indicate your general level of anxiety over the last month by circling one of the numbers on the 1 to 10 scale below. The higher the number indicated, the higher the level of anxiety, nervousness, and tension you are reporting.

1 2 3 4 5 6 7 8 9 10
Peaceful Panicky

Now mark an "X" over one of the numbers to describe the high level of your anxiety during the last month.

1 2 3 4 5 6 7 8 9 10
Peaceful Panicky

Personal Assessment

Please list three things you feel are your main strengths.

What would you say are you top three difficulties?

How do you feel that counseling can be helpful for you?

Other Thoughts

Please add or emphasize any other information which you would like your counselor to know so that he may better understand you. Use the back of this page if needed.