Grace P. Ravenelle, LCPC
Licensed Clinical Professional Counselor
Phone: 775 237 3159
Email: contact@helpwithgrace.com

Grace P. Ravenelle, MS, Licensed Clinical Professional Counselor
Medical and Psychological History Form For ADULTS

Client's Name (Self-only): _____Date: _____

Section 1 – Personal History:

Please indicate whether you have had any of the following symptoms by placing a check next to anything that applies. Anything left blank is assumed to not apply. If you have other symptoms not listed, please inform me.

Severity Scale 1-10 is listed as such:
10 = "I can't function most days"; 1 = "This doesn't affect me most days"

_____ Anxiety **Severity** 10=REALLY Bad 1 =Does Not Affect Me (1-10) _____

_____ Depression **Severity** 10=REALLY Bad 1 =Does Not Affect Me (1-10)_____

_____ Recent Loss/Death of a Loved One

_____ Sexual Problems

_____ Relationship Problems

_____Suicide Attempts or Suicidal Thought

_____ Recent Job Loss or Major Career Change

_____ Miscarriage or Stillbirth

Severity 10=Very Suicidal 1=No Thoughts of Suicide now or recently (1-10) _____

_____ Thoughts of Self-Harm 10= REALLY Bad 1 =Does Not Affect Me **Severity** (1-10) _____

_____ Medical Problems that interfere with my quality of life or relationships
10=REALLY Bad 1 =Does Not Affect Me **Severity** (1-10) _____

_____ History of Trauma, Neglect, or Abuse **If yes**, What age(s)? _____ Was this Sexual in nature? _____

_____ Have you or your Partner Had an Affair? _____ Me _____ Partner/Spouse

If yes, When? _____ Are you still in contact with the affair partner? **Y/N**

Does your Spouse know about the Affair? **Y/N**

If No, are you willing to work on disclosing this to your partner? **Y/N**

Are you willing to end your extramarital relationship in order to commit to working on the relationship/marriage? **Y/N**

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For Couples, How Important is it that we address sexual intimacy as part of our work together?

_____ Not at all, we're happy with our Sex Life

_____ I'd like to address it, I have some concerns

_____ Extremely Important

Quality of my Connection with my Family of Origin (Parents/Siblings):

____ Very Close _____ Good but not Super Close _____Distant

_____ We Don't talk or get along

Section 2 - Brief Drug/Addiction History: Please record your drug history by checking any that apply to you.

Past	**Present**		**Past**	**Present**	
_____	____	Alcohol	____	____	Cocaine
_____	____	Marijuana	____	____	Opiates
_____	____	LSD	____	____	Inhalants
_____	____	Methamphetamines	____	____	Recreational Use of Prescription Drugs
_____	____	Pornography			

If Present use, Frequency?

_____ Daily _____ Multiple Days Per Week

_____ Occasionally (2x or less per month)

_____ Regularly Daily/Weekly and Monthly Other?_____

Have you ever been to a drug treatment program, rehab program, or group such as AA/NA/SA? **Y/N**

If yes, When? _____ If You view Pornography, since what age? _____

Is this viewed alone? **Y/N** Do you watch it with your spouse/Partner? **Y/N**

Does your Spouse/Partner know about your pornography use? **Y/N**

Y/N My Spouse/Partner has complained or frequently complains about my Pornography Use

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Do you play video games? Y/N If yes, Frequency?

_____ Daily _____ Multiple Days Per Week

_____ Occasionally (2x or less per month)

_____ Regularly Daily/Weekly and Monthly

Y/N My Spouse complains/would say my video game use is a problem in our relationship