1116 Key St. Suite 209
Bellingham, WA 98225
(360) 325-9626
brittanylbruner@gmail.com

Brittany Bruner MA, LMFT, CMHS
Associates in Mental Health

Client Health History and Background

Please provide the following information for my records. Continue on the backside of this form if you need additional space.

General Information

Name: ______________________________________
Date:_______________________

Birth Date: ______ /______ /______ Age: ________

What brings you to seek my services at this time? What is the problem, concern or issue needing to be addressed?

____

____

When did it begin? Briefly describe the history of the concern:

____

____

Are you currently receiving psychological services, professional counseling or therapy elsewhere?

____

Have you had previous therapy? □Yes □No
If yes, what was helpful/not helpful?

____

____

Health and Social Information

1. How is your physical health at present? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any previous, ongoing or recent physical symptoms or health concerns (e.g. chronic pain, headaches, injuries, chronic medical conditions, hospitalizations, surgeries, accidents, etc.):

____

____

3. How are these symptoms or concerns affecting you, your functioning at work or school, social or family relationships, quality of life, and sense of well-being?

____

____

Brittany Bruner MA, LMFT, CMHS
Associates in Mental Health

1116 Key St. Suite 209
Bellingham, WA 98225
(360) 325-9626
brittanylbruner@gmail.com

4. Are you taking any medications for the symptoms or conditions described above or for other conditions (over the counter and/or prescription)?

____
____

5. Are you currently taking prescribed psychotropic medication (e.g. antidepressants)?
□No □Yes
If yes, please list:

____

Have you previously been prescribed psychiatric medication? □ No □ Yes
If yes, please list (what and when):

____

6. Sleep: Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much
□ Poor quality sleep □ Disturbing dreams
□ Other

____

7. Exercise/Physical Activity:
How many times per week do you exercise? _______________________________
Approximately how long each time?____
Intensity level: □ Low □ Medium/moderate □ High □ Very strenuous □ Varies
What physical activities do you engage in?

____

8. Diet and Nutrition: Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable:
□ Eating less □ Eating more
□ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

On a scale of 1-10, how would you rate the healthiness of your diet?

____

9. Do you smoke? □ No □ Yes Regularly use alcohol? □ No □ Yes
In a typical month, how often do you use alcohol, how many drinks each time?_____________________

10. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely
□ Never
What kinds? ______________________________________

Brittany Bruner MA, LMFT, CMHS
Associates in Mental Health

1116 Key St. Suite 209
Bellingham, WA 98225
(360) 325-9626
brittanylbruner@gmail.com

Have you ever been in Drug or Alcohol Treatment? ☐ No ☐ Yes
If yes, please explain details:
____

11. Have you had suicidal thoughts recently?
☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Have you had them in the past?
☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

15. In the last year, have you experienced any significant life changes or stressful events?
☐ No ☐ Yes If yes, please describe:
____
____

16. Are there any situations or circumstances in your current life in which you feel afraid?
☐ No ☐ Yes If yes, please describe:
____

17. Have you ever experienced:

Extreme depressed mood	☐ No	☐ Yes
Wild Mood Swings	☐ No	☐ Yes
Rapid Speech	☐ No	☐ Yes
Extreme Anxiety	☐ No	☐ Yes
Panic Attacks	☐ No	☐ Yes
Phobias	☐ No	☐ Yes
Sleep Disturbances	☐ No	☐ Yes
Hallucinations	☐ No	☐ Yes
Unexplained losses of time	☐ No	☐ Yes
Unexplained memory lapses	☐ No	☐ Yes
Alcohol/Substance Abuse	☐ No	☐ Yes
Frequent Body Complaints	☐ No	☐ Yes
Eating Disorder	☐ No	☐ Yes
Body Image Problems	☐ No	☐ Yes
Repetitive Thoughts (e.g. Obsessions)	☐ No	☐ Yes
Repetitive Behaviors (e.g. Frequent Checking, etc.)	☐ No	☐ Yes
Homicidal Thoughts	☐ No	☐ Yes
Suicide Attempt	☐ No	☐ Yes

Brittany Bruner MA, LMFT, CMHS
Associates in Mental Health

1116 Key St. Suite 209
Bellingham, WA 98225
(360) 325-9626
brittanylbruner@gmail.com

If you answered 'yes' to any of the above or have other distressing experiences, please provide details here:

____
____
____

Occupational Information

Are you currently in school? □ No □ Yes
If yes, what grade and what school do you attend?

____

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position?

____

Religious/Spiritual Information

Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith?

____
If no, do you consider yourself to be spiritual? □ No □ Yes

Would you prefer to have your spiritual/religious values & beliefs to be part of the counseling process and conversation? □ No □ Yes

Family Physical & Mental Health History

Has anyone in your family (either immediate or distant relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.)

Major Illness / Health Event	□ No	□ Yes
Chronic Health Condition	□ No	□ Yes
Major Injuries/Trauma	□ No	□ Yes
Early/Sudden Death	□ No	□ Yes
Depression	□ No	□ Yes
Bipolar Disorder	□ No	□ Yes
Anxiety Disorders	□ No	□ Yes
Panic Attacks	□ No	□ Yes
Schizophrenia	□ No	□ Yes
Alcohol/Substance Abuse	□ No	□ Yes
Eating Disorders	□ No	□ Yes
Learning Disabilities	□ No	□ Yes
Trauma /Abuse History	□ No	□ Yes
Suicide Attempts	□ No	□ Yes

Other Information

Brittany Bruner MA, LMFT, CMHS
Associates in Mental Health

1116 Key St. Suite 209
Bellingham, WA 98225
(360) 325-9626
brittanylbruner@gmail.com

What are your goals for therapy?

What will indicate to you that you have reached your goals? How will you feel, think, know, be and act at that time, different from today?

Anything else you'd like me to know?

Client Name (Printed): ____

Signature: ____ **Date:** ____________