## Jennifer McMillan, LMFT, LMHP

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### PROBLEMS & STRENGTHS

Client Name:_______________________________________________________________________

Today's Date:______________________________________ Client Age:_____________________

## Please describe the reasons for our visit:

_______________________________________________________________________________

_______________________________________________________________________________

**Check any of the symptoms that the client is currently experiencing:**

___Depressed mood
___Change in eating habits
___Difficulty with school
___Low self-esteem
___Perfectionism
___Problems with sleeping
___Feeling fearful

___Tearful/crying spells
___Lack of energy
___Worries
___Feeling stressed
___Feeling hopeless
___Irritability
___Self harm

___Fire setting
___Obsessions or compulsions
___Sudden feelings of panic
___**Thoughts of killing self***
___**Seeing things others do not***
___**Other***: __________________

***Describe in detail:**

_______________________________________________________________________________

_______________________________________________________________________________

**PRIOR COUNSELING HISTORY:**

Therapist name(s):_______________________________________________________________

___Feeling worried
___Relationship/friendship problems
___Toileting problems
___Trouble concentrating
___Physical complaints
___Separation
___Tantrums
___Anger outbursts
___Difficulty enjoying usual activities

___Bedwetting
___Problems at school
___Weight/appetite changes
___Memory problems
___Acting violently
___Feeling of extreme happiness
___Isolation/withdrawal
___Harm to animals
___**Thoughts of killing others***

**Current and/or prior psychiatric medication history (include doctor's name):**

_______________________________________________________________________________

_______________________________________________________________________________

**Name of current medications and dosage(s):**

_______________________________________________________________________________

_______________________________________________________________________________

**CHECK HERE IF N/A ____**

**MEDICAL HISTORY:**

Has the client been seen by a doctor within the last year? ___Yes ___No
Purpose of visit:

________________________________________________________________________________

________________________________________________________________________________

Client Primary Care Provider: ___________________________________ Phone:__________________

Please list any prescription or over-the-counter medications currently being taken:

________________________________________________________________________________

________________________________________________________________________________

Please list any major medical problems, such as serious illness, operations, injury, or head trauma:

________________________________________________________________________________

List of allergies:

________________________________________________________________________________

________________________________________________________________________________

**SCHOOL HISTORY**

**Current school:**_________________________________________________________________

Past school(s):___________________________________________________________________

Please check all that apply:

____Suspensions
____IEP/504 Plan
____Peer Issues
____Participation in groups at school
____Meetings with school due to behaviors
____Separation Issues
____Academic challenges

**Stressful Events:** Please describe any history of parental separation, divorce, major family conflict, moves, major accidents, medical issues, deaths, abuse (physical, sexual, or emotional), etc.

________________________________________________________________________________

________________________________________________________________________________

**What are your goals for therapy:**

________________________________________________________________________________

________________________________________________________________________________

**Please describe three strengths of your child:**

________________________________________________________________________________

________________________________________________________________________________

**Please describe three strengths of your family:**

________________________________________________________________________________

________________________________________________________________________________