Ethos Leaders LLC Counseling Services
Bryant Kusy, MA, LCPC, IMH-E IV
1243 E Iron Eagle Dr. Suite 130D Eagle, ID 83616
Phone: (208) 391-7050
FAX: (208) 547-6835

Client Personal Information & History

Client Name _____ Date of Birth _____
Client's Age_____ Male / Female
Home Phone _____ Cell Phone _____

Emergency Contact _____
Relationship _____
Home Phone _____ Cell Phone _____

Name of Person Completing Form _____
Relationship to Client_____

REASON FOR SEEKING TREATMENT
List below the presenting challenges or concerns:

_____
_____
_____
_____
_____
_____

What is most concerning about this problem?

_____
_____
_____

When was the above problem first noticed?

_____

What is important about your seeking guidance NOW?

_____

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How has this problem affected your functioning?
Home _____
Work/School_____
Community_____

Have you received counseling services in the past? Yes / No

What was your diagnosis during this time? _____
_____
What was the outcome of this treatment? _____

RELATIONSHIPS
Are you currently married? Yes / No
Divorced? Yes / No Date: _____
Widowed? Yes / No Date: _____
In a romantic relationship? Yes / No _____
Spouse/Partner's Name: _____
How long have you been together? _____
Please list names and ages of children:
Name: _____ Age: _____
Name: _____ Age_____
Name: _____ Age: _____
Name: _____ Age: _____
Anyone else living in the home?
Name: _____ Age_____
Relationship: _____
Name: _____ Age_____
Relationship: _____
Is there anyone you trust or confide in during times of trouble? _____

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Do you have enough CLOSE friendships? Yes / No Who?

Do you have any pets? Yes / No

EDUCATION

High School Diploma: Y / N School_____ Year_____
GED Program_____ Year_____
College/University Degree: Y / N School _____Year_____ Degree: _____

EMPLOYMENT

Are you currently employed? Yes / No How long at this employment? _____
Employer _____

Employment address _____
Employment phone _____

RELIGION

Do you have a faith/religious/spiritual practice? _____

HEALTH

How would you rate your current level of physical health? Poor Fair Good Excellent
Do you struggle with chronic illness or health challenges? Please list:

_____ _____
_____ _____

How would you rate your sleep? Poor Fair Good Excellent

PRESCRIPTIONS

Please list any prescription medications you are currently taking and **prescribing physician**:

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Medication Name _____Dose in mg. _____Physician_____ Condition _____
Medication Name _____Dose in mg. _____Physician_____ Condition _____
Medication Name _____Dose in mg. _____Physician_____ Condition _____
Medication Name _____Dose in mg. _____Physician_____ Condition _____

Do you take herbal supplements/vitamins? If yes please list:

_____ _____
_____ _____

Please list any **ALLERGIES** to medication, past or present:

_____

SUBSTANCE ABUSE

PAST alcohol, tobacco and/or drug abuse issues? Yes / No
CURRENT alcohol, tobacco and/or drug abuse issues? Yes / No
Please explain:

_____
_____
_____

Substance abuse treatment? Yes / No Voluntary Court Ordered
Please describe: _____
_____

LEGAL

Have you ever been arrested? Yes / No Charges: _____
Are you currently on probation/parole? Yes / No _____
Is this therapy/consultation court ordered? Yes / No Order # _____

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Any other legal stressors? _____

TRAUMA

Have you been a victim of:
Sexual abuse? Yes / No
Physical abuse? Yes / No
Emotional abuse? Yes / No
Auto accidents?
Other life threatening events?
Please explain:_____
_____
_____

Was anyone ever charged and/or arrested for any of the abuse identified above? Yes / No
What was the outcome of the case?
_____

Is there a Protection Order in place? Yes / No Date: _____ Expires: _____

FAMILY HISTORY OF MENTAL ILLNESS

Do you have a family history of mental illness? Yes / No
Please list and explain (i.e. maternal aunt Depression) include siblings:

Mother's Side: Father's Side:

Please identify which members of your family have had issues with the following:
Please circle all that apply:

Bipolar	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother
Depression	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother
Anxiety, OCD	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother

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Depression	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother
Anxiety, OCD	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother
ADD, ADHD	Father Mother Sibling(s) Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother

Have you or anyone in your family attempted and/or completed a suicide? Yes / No
Please explain: _____
_____

Have you ever been hospitalized in a psychiatric facility? Yes / No When? _____
Where? _____

What else I should know about you?_____
_____
_____

What are your unique gifts and strengths? _____
_____
_____

Describe yourself in at least FIVE words:

_____

_____

_____

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