B.Y.R.C.S
4250 Cessna St
Bldg 270
Boise, ID 83705
Office:(208) 272-8393
(208) 272-8392
Beyond the Yellow Ribbon Counseling Services

Client Background Information

Please answer all information as completely as possible. Information will be managed as protected health information and beneficial in providing the best possible service.

Name: _____ **Date**: _____

Address:_____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**:_____

May call ☐ Yes ☐ No May call ☐ Yes ☐ No May call ☐ Yes ☐ No

Message ☐ Yes ☐ No Message ☐ Yes ☐ No Message ☐ Yes ☐ No

Best time/place to contact you: _____

E-mail address:_____

Gender: _____ Date of Birth: _____ Age: _____

Race/Culture:_____ Occupation:_____ Household Income: _____

In case of emergency, contact:

_____

Name Relationship Phone

Education Level:

☐ 8th Grade or Below ☐ High School ☐ Some College ☐ College Graduate

Marital Status:

❑ Single ❑ Living with Partner ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Years:_____

Present Family:

Please identify the family you currently live with and current nature of your relationship with each member. *Including yourself, list the members of your current family from oldest to youngest. Use back if more space is needed*

Name	Relationship	Age	Currently this relationship is ... *i.e. good, neutral, conflictual etc.*

Health History:
Are you currently under the care of a physician or psychiatrist? ☐ Yes ☐ No
If yes:
Name:_____
Phone: _____
Date of LAST complete physical exam: _____
Any significant results: _____

Physical Disability: Yes ☐ No ☐ Chronic Illness: Yes ☐ No ☐

If yes to either, please explain:
_____

Are you currently taking any medication or homeopathic? Yes ☐ No ☐

Name of Current Medication	Dosage	Frequency	Purpose	Prescribing Doctor

Please list past and current medical conditions (major illness/injuries/surgeries/etc.)

What	When	Treatment

Are you in physical pain? ☐ Yes☐ No If yes, where? _____
What type of Pain do you experience? (Dull, Sharp, Nagging, Burning, Other) _____
_____
How long have you experienced this type of Pain? _____
Please rate your Pain today: 1 2 3 4 5 6 7 8 9 10
On a good day: _____ On a bad day: _____

Mental Health History:

Treatment Experience	YES	NO	INPATIENT/ OUTPATIENT	WHEN	WAS IT HELPFUL?		
Individual Counseling					YES	SOME	NO
Couples Counseling					YES	SOME	NO
Developmental Therapy/PSR					YES	SOME	NO
Psychiatric Services					YES	SOME	NO
Drug/Alcohol/Sexual Addiction Treatment					YES	SOME	NO
Self-Help Group					YES	SOME	NO
Hospitalization					YES	SOME	NO

Have you ever or are you currently contemplating ending your life? ☐ Yes ☐ No
Have you ever or are you currently contemplating harming yourself? ☐ Yes ☐ No
Has anyone in your immediate family attempted or committed suicide? ☐ Yes ☐ No

Did someone refer you to BYRCS? ❑ Y ❑ N If so, who? _____

Sexuality:
What sexual issues would you like to discuss during treatment?
_____
Have you ever been sexually and or physically abused? YES ☐ NO ☐

Alcohol/Substance Use:

Which of the following substances do you currently use:

☐Alcohol ☐Tobacco ☐Narcotics ☐Prescription ☐Other: _____

Date of last use:_____
Type and amount of usage? _____
_____
Age usage began? _____

How often do you use/consume? _____

Have you ever had any legal problems related to your use/consumption? □Yes □No

Have you ever had any relationship problems related to your use/consumption? □Yes □No

Has your use/consumption ever become a problem? □Yes □No

Interests/Hobbies:

Do you participate in any social activities? □Yes □No

Please list your hobbies or interests: _____

_____

Spirituality:

Do you practice a faith or religion? □ Yes □ No If so, please identify: _____

Would you like faith to be a part of treatment? □ Yes □ No

If Yes, please describe what this might look like? _____

Current Concerns:

What brought you into treatment?

_____

_____

_____

What are your expectations for treatment?

_____

_____

_____

How will you know if treatment is working?

_____

_____

_____

What is the one thing that you want me to know about you today?

_____

_____

_____

PRESENTING PROBLEMS/FEELINGS/EXPERIENCES (Check all that apply)

- ☐ Aggressive Behavior
- ☐ Alcohol Abuse/Dependency
- ☐ Anger
- ☐ Anxiety
- ☐ Change in Appetite
- ☐ Compulsions
- ☐ Cutting/Injuring
- ☐ Delusions/Hallucinations
- ☐ Depression
- ☐ Easily Annoyed
- ☐ Easily Distracted
- ☐ Eating Disorder
- ☐ Emotional Abuse
- ☐ Excessive Worry
- ☐ Family Issues
- ☐ Fatigue
- ☐ Fearful
- ☐ Financial
- ☐ Friendship
- ☐ Grief/Loss
- ☐ Guilt/Worthlessness
- ☐ Headaches
- ☐ Hearing Things
- ☐ Hopeless
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Intimacy
- ☐ Irritable
- ☐ Life Decision
- ☐ Loss of Pleasure
- ☐ Mania
- ☐ Medical/Organic Condition
- ☐ Mood Instability
- ☐ Muscle Tension
- ☐ Pain
- ☐ Panic
- ☐ Paranoia
- ☐ Parenting
- ☐ Physical Abuse
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Relationships
- ☐ Restless
- ☐ Sadness
- ☐ School
- ☐ Seeing Things
- ☐ Self-Destructive Behavior
- ☐ Sex Compulsion/Dependency
- ☐ Sexual Abuse
- ☐ Sexuality
- ☐ Sleeping Too Little
- ☐ Sleeping too much
- ☐ Spirituality
- ☐ Stomachaches
- ☐ Stress
- ☐ Substance Abuse/Dependency
- ☐ Suicidal Ideation
- ☐ Tearful
- ☐ Trauma
- ☐ Uncertain
- ☐ Work
- ☐ Other: _____

Please identify and rate the six feelings or experiences that are most troubling for you currently from most severe to least severe:

#1:_____ #2:_____ #3: _____

#4:_____ #5:_____ #6: _____

Approximately how long have these been bothering you? _____

Approximately how much distress do you believe these problems are causing in your life?

- ☐ Mild (less than once a week)
- ☐ Moderate (1-2 times per week)
- ☐ Severe (4-5 times per week)
- ☐ Impairing (Daily)