

**PERSONAL INFORMATION AND HISTORY**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MOBILE NUMBER: \_\_\_\_\_

WORK NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

NUMBER OF MONTHS/YEARS AT PRESENT JOB: \_\_\_\_\_

HIGHEST LEVEL OF EDUCATION COMPLETED: \_\_\_\_\_

SCHOOL/PROGRAM: \_\_\_\_\_ YEAR IN SCHOOL: \_\_\_\_\_

CULTURAL BACKGROUND: \_\_\_\_\_

RELATIONSHIP STATUS: SINGLE PARTNERED MARRIED SEPARATED DIVORCED WIDOWED  
FOR HOW LONG? \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

**FAMILY INFORMATION:**

NAME	AGE	LIVES W/YOU?	OCCUPATION
PARTNER/SPOUSE:			
CHILDREN:			
STEPCHILDREN:			
MOTHER:			
FATHER:			
SIBLINGS:			
STEPPARENTS:			
STEPSIBLINGS:			
OTHERS IN HOUSEHOLD:			

**CURRENT MEDICATIONS:**

PLEASE NOTE IF YOU ARE CURRENTLY TAKING ANY MEDICATION, FOR ANY REASON. INCLUDE BIRTH CONTROL, HOMEOPATHIC, HERBAL, AND OTHER REMEDIES.

MEDICATION	DOSAGE	HOW LONG

**FAMILY HISTORY:**

PLEASE NOTE IF YOU HAVE ANY FAMILY MEMBERS (BOTH GENETICALLY AND NOT GENETICALLY RELATED) WHO HAVE HAD EMOTIONAL OR SUBSTANCE ABUSE PROBLEMS INCLUDING ANXIETY, DEPRESSION, ALCOHOL/DRUG ABUSE, EATING DISORDERS, "NERVOUS BREAKDOWNS," SCHIZOPHRENIA, MANIC DEPRESSION/BIPOLAR DISORDER, AND SUICIDE. PLEASE NOTE IF THEY WERE HOSPITALIZED FOR THESE PROBLEMS.

NAME	PROBLEM	RELATIONSHIP TO YOU

**THERAPY HISTORY:**

PLEASE NOTE IF YOU HAVE BEEN IN INDIVIDUAL, FAMILY, OR COUPLES THERAPY BEFORE.

THERAPIST'S NAME	REASON FOR THERAPY	WHERE	WHEN	HOW LONG

**HOSPITALIZATION HISTORY:**

PLEASE NOTE IF YOU HAVE BEEN HOSPITALIZED FOR A PSYCHIATRIC REASON.

REASON FOR HOSPITALIZATION	DATES	HOSPITAL NAME

WHAT CONCERNS HAVE BROUGHT YOU HERE, AND WHAT ARE YOUR GOALS FOR THIS VISIT?

HOW LONG HAVE YOU HAD THESE CONCERNS?

WHAT, IF ANYTHING, HAVE YOU DONE IN THE PAST TO TRY TO DEAL WITH THESE CONCERNS?

PLEASE INDICATE ALL ITEMS THAT APPLY TO YOU (USE C OR P FOR CURRENT OR PAST):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> POOR CONCENTRATION                     | <input type="checkbox"/> STRANGE EXPERIENCES                         | <input type="checkbox"/> SURVIVOR OF EMOTIONAL ABUSE            |
| <input type="checkbox"/> WORRIES OR ANXIETY                     | <input type="checkbox"/> DYSFUNCTIONAL FAMILY                        | <input type="checkbox"/> DIFFICULTY WITH FRIENDS                |
| <input type="checkbox"/> UNUSUAL THOUGHTS                       | <input type="checkbox"/> PASSIVE/WITHDRAWN                           | <input type="checkbox"/> SADNESS OR DEPRESSION                  |
| <input type="checkbox"/> DEATH/ILLNESS OF<br>SIGNIFICANT PERSON | <input type="checkbox"/> IMPULSE TO HURT OTHERS<br>OR DESTROY THINGS | <input type="checkbox"/> DEVELOPING INDEPENDENCE<br>FROM FAMILY |
| <input type="checkbox"/> LEGAL PROBLEMS                         | <input type="checkbox"/> RECENT BREAK-UP                             | <input type="checkbox"/> EXPERIENCED A TRAUMATIC EVENT          |
| <input type="checkbox"/> ALWAYS TIRED                           | <input type="checkbox"/> EXCESSIVE FEAR                              | <input type="checkbox"/> SURVIVOR OF RAPE/VIOLENCE              |
| <input type="checkbox"/> TEARFULNESS                            | <input type="checkbox"/> INDECISIVENESS                              | <input type="checkbox"/> ADJUSTMENT TO SCHOOL/WORK              |
| <input type="checkbox"/> HEADACHES                              | <input type="checkbox"/> FEELING WORTHLESS                           | <input type="checkbox"/> IMPULSE TO HURT OR CUT SELF            |
| <input type="checkbox"/> STOMACH TROUBLE                        | <input type="checkbox"/> RECURRING THOUGHTS                          | <input type="checkbox"/> FEAR OF LOSS OF CONTROL                |
| <input type="checkbox"/> LONELINESS, ISOLATION                  | <input type="checkbox"/> SLEEP PROBLEMS                              | <input type="checkbox"/> INABILITY TO ENJOY LIFE                |
| <input type="checkbox"/> IRRITABILITY/ANGER                     | <input type="checkbox"/> DIFFICULT RELATIONSHIP                      | <input type="checkbox"/> SEXUALLY ABUSED                        |
| <input type="checkbox"/> FEELING HOPELESS                       | <input type="checkbox"/> POOR MEMORY                                 | <input type="checkbox"/> FEELING TENSE                          |
| <input type="checkbox"/> POOR MOTIVATION                        | <input type="checkbox"/> SEXUALITY ISSUES                            | <input type="checkbox"/> ALCOHOL/DRUG USE                       |
| <input type="checkbox"/> PANIC ATTACKS                          | <input type="checkbox"/> FAMILY CONFLICT                             | <input type="checkbox"/> PHYSICALLY ABUSED                      |
| <input type="checkbox"/> EATING PROBLEMS                        | <input type="checkbox"/> RECENT MOVE                                 | <input type="checkbox"/> SUICIDAL THOUGHTS/FEELINGS             |
| <input type="checkbox"/> DIETING                                |  |   |
| <input type="checkbox"/> COMPULSIVE OVEREATING                  |  | <input type="checkbox"/> WEIGHT CHANGE                          |
| <input type="checkbox"/> BINGEING                               |  | LOSS (LBS.____)   |
| <input type="checkbox"/> VOMITING OR OTHER PURGING              |  | GAIN (LBS.____)   |
| <input type="checkbox"/> EXCESSIVE EXERCISE                     |  |   |
| <input type="checkbox"/> FASTING/AVOIDING FOOD                  |  |   |

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE ME TO KNOW?