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/Gender identity: _____

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):

_____ POOR CONCENTRATION
_____ WORRIES OR ANXIETY
_____ UNUSUAL THOUGHTS
_____ DEATH/ILLNESS OF SIGNIFICANT PERSON
_____ LEGAL PROBLEMS
_____ ALWAYS TIRED
_____ TEARFULNESS
_____ HEADACHES
_____ STOMACH TROUBLE
_____ LONELINESS, ISOLATION
_____ IRRITABILITY/ANGER
_____ FEELING HOPELESS
_____ POOR MOTIVATION
_____ PANIC ATTACKS
_____ EATING PROBLEMS
  _____ DIETING
  _____ COMPULSIVE OVEREATING
  _____ BINGEING
  _____ VOMITING OR OTHER PURGING
  _____ EXCESSIVE EXERCISE
  _____ FASTING/AVOIDING FOOD

_____ STRANGE EXPERIENCES
_____ DYSFUNCTIONAL FAMILY
_____ PASSIVE/WITHDRAWN
_____ IMPULSE TO HURT OTHERS OR DESTROY THINGS
_____ RECENT BREAK-UP
_____ EXCESSIVE FEAR
_____ INDECISIVENESS
_____ FEELING WORTHLESS
_____ RECURRING THOUGHTS
_____ SLEEP PROBLEMS
_____ DIFFICULT RELATIONSHIP
_____ POOR MEMORY
_____ SEXUALITY ISSUES
_____ FAMILY CONFLICT
_____ RECENT MOVE

_____ SURVIVOR OF EMOTIONAL ABUSE
_____ DIFFICULTY WITH FRIENDS
_____ SADNESS OR DEPRESSION
_____ DEVELOPING INDEPENDENCE FROM FAMILY
_____ EXPERIENCED A TRAUMATIC EVENT
_____ SURVIVOR OF RAPE/VIOLENCE
_____ ADJUSTMENT TO SCHOOL/WORK
_____ IMPULSE TO HURT OR CUT SELF
_____ FEAR OF LOSS OF CONTROL
_____ INABILITY TO ENJOY LIFE
_____ SEXUALLY ABUSED
_____ FEELING TENSE
_____ ALCOHOL/DRUG USE
_____ PHYSICALLY ABUSED
_____ SUICIDAL THOUGHTS/FEELINGS

_____ WEIGHT CHANGE
  LOSS (LBS.___)
  GAIN (LBS.___)

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