Name _____ Date _____

Psychological/Medical History

Name of Primary Physician Address Phone Number Date of Last Visit

1. Please name all other professionals currently treating you and for what condition(s)

2. List any current physical or medical problems or conditions, accidents, hospitalizations, allergies and all prescriptions

Incident Date Medical Condition/Diagnosis Were you Hospitalized Resulting Prescriptions

3. Please describe any current and past usage of alcohol and recreational drugs

4. If you have sought psychotherapy services before please answer the following:

Therapist's Name	Treatment Length	Reason for Treatment

5. Please state briefly why you seek psychotherapy service now:

For a minor client, name of person who is legally responsible for care and physical custody

The above information is correct to the best of my knowledge. I will notify you of any changes in this information.

Signature of Person Completing This Form Printed Name Relationship to Client Date

Name _____ Date _____

ADDITIONAL INFORMATION:

1. Are you currently employed No Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What do you consider as some of your strengths?

4. What do you consider as some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

6. Are you currently experiencing anxiety, panic or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? No Yes

If yes, please describe

_____

Name _____ Date _____

8. Do you drink alcohol more than once per week? No Yes

   If yes, how many days/ week? _____

9. How often do you engage in the use of recreational drugs? (please circle one)
   Daily Weekly Monthly Never Infrequently

10. Are you currently in a romantic relationship? No Yes

    If yes, for how long? _____
    On a scale of 1-10, with 10 being the best, would you rate your relationship? _____

11. How would you rate your current physical health? (please circle one)
    Poor Unsatisfactory Satisfactory Good Excellent

12. How would you rate your current sleeping habits? (please circle one)
    Poor Unsatisfactory Satisfactory Good Excellent

13. How many times per week do you exercise? _____
    What type of exercises do you participate in? _____

14. Do you currently experience any difficulty with appetite, eating pattern, etc?
    No Yes
    If yes, explain _____

15. Are you experiencing any overwhelming sadness, grief or depression? No Yes
    If yes, for how long? _____

16. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

17. Are you currently taking any prescription medication? No Yes

    If yes, please list:

_____

_____

_____

18. Have you ever been prescribed any psychiatric medication? No Yes

    If yes, please list and provide dates:

_____

_____

_____

Name _____ Date _____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, mother, grandparent, uncle, etc.)

		Family Member			Family Member
Alcohol Abuse	yes/no		Substance Abuse	yes/no	
Anxiety	yes/no		Depression	yes/no	
Domestic Violence	yes/no		Eating Disorders	yes/no	
Obesity	yes/no		Schizophrenia	yes/no	
Suicide Attempt	yes/no		Obsessive Compulsive Behavior	yes/no	