

FAMILY INFORMATION

Marital status – current: Single Married Divorced Separated Widow/er Partner Dating

Spouse/Partner Name: _____ **Spouse/Partner Birthdate:** _____

Length of Marriage/Relationship: _____

Children: Names and Ages: _____

Are your children living with you? Yes No

Parents: Father: Age _____ Occupation _____ Mother: Age _____ Occupation _____

Did you grow up with both parents in the home? Y N If your parents divorced, what age were you? _____

Did your parents remarry following divorce? Y N If yes, what age were you? _____

List names and ages of family members involved in therapy _____

Please indicate any family history of the following by checking the appropriate box.

- | | |
|--|---|
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Chronic Mental Illness |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Suicidality | <input type="checkbox"/> Other: _____ |

TREATMENT/THERAPY HISTORY

Are you currently in therapy elsewhere? Y / N

Have you ever had any previous counseling or psychotherapy? Y N If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y N If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y N If Yes, when? _____ Length of hospital stay _____

MEDICAL INFORMATION

Current Weight _____ One Year Ago _____ Maximum _____ When _____

Do you exercise regularly? Y N How? _____

Do you sleep well? Y N Amount (hours) _____ Easy to get to sleep? Y N

Primary Physician _____ City _____ Date of last physical _____

Please list all current medications:

MEDICATION	DOSE	REASON

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias (Fears)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over-eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing/Seeing things that are not there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Packs per week	_____			
Alcohol Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Frequency (per week):	_____			
• How Much?	_____			
• What do you drink?	_____			
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Amount per week:	_____			
Drugs (not medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• What?	_____			
• Frequency:	_____			

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Relievers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives/Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list all current medications:
Comments: