Patient Name: ______________________________ Date: _____________

Patient Information:

Date: __________________ Therapist: ____

Client Name: __________________________ Phone: _______________________________________

Address: ____________________________________City:____________________ Zip: ___________

E-mail address: ____ (NEVER shared or sold; for newsletter)

Age: _______ Birth Date: ___________ Marital: M S W D Committed Relationship

Occupation _________________________ Employer: ____

Spouse:__________________ Occupation: ________________Employer:_______________________________

How many children? ____________ Names and Ages of Children:
____

Name of Emergency Contact: _______________________________Phone:_______________________________

How did you hear about me? ____

Family Medical Doctor (first and last name): ________________________________ City: ____________________

Month and year of last physical: ____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _______ Initial here

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment: ____
____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:
____
____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety	__Eating Disorder
__ Depression	__ Post Traumatic Stress Disorder
__ Anger	__ Adoption Issues
__ Abandonment	__ Other. List: _____________________________
__ Alcoholism	__ Other. List: _____________________________
__ Drug Addiction	__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth____
____

Patient Name: ______________________________ Date: ____________

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: ____

What medications or drugs are you taking? (List name and dosage)

____

____

Please list any other health problems you have, no matter how insignificant they may be: ___________________

____

____

Have you been in counseling before? No__ Yes__ If yes, year and therapist name:

Have you been hospitalized for substance abuse or inpatient psychiatric treatment?

No__ Yes__ if yes, where and year: ____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ______ If so, how much per week? ______________________________

Do you use any tobacco products? ______Do you smoke? ____ if so, packs per day: ____________________

Do you take vitamin supplements? ______ if so, please list: ____________________________________

Do you consume caffeine? _____ If so, how much per day: _____________________________________

Do you exercise?_____

Do you sleep well at night? _____ If no, why not? _______________________________________

What are your hobbies?____

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:

Parents:

Father: living ___ deceased ____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____

Mother: living ___ deceased ____ (check one) Current age if still living: ______ Cause of death and age at death if deceased: ____

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _________

____

Patient Name: ______________________________ Date: _____________

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety	__Eating Disorder
__ Depression	__ Post Traumatic Stress Disorder
__ Anger	__ Adoption Issues
__ Abandonment	__ Other. List: ______________________________
__ Alcoholism	__ Other. List: ______________________________
__ Drug Addiction	__ HIV Positive

AUTHORIZATION AND RELEASE: I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care.

Patient's Signature: ____ Date: _______________

Case History **Name** _____________________________________ **Date** _________________

1. What is your major concern? ____

   ____

   ____

   ____

   Other concerns: ____

   ____

   ____

2. If this is a recurrence, when was the first time you noticed this problem?_________________________

   How did it originally occur?____

   ____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? ____

   ____

3. How frequent is the condition? Constant _____ Intermittent ____

   What causes the problem to come on/get worse?

   ____

   ____

Patient Name: ______________________________ Date: _____________

4. Are there any other conditions you would like to discuss?

   Yes _____ No _____. If yes, describe:

   ____

   ____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________

   ____

5. Is there anything you can do to relieve your major problem? Yes ___ No ___. If yes, describe:

   ____

   If no, what have you tried to do that has not helped? ________________________________

   ____

6. What makes the problem worse? ____

   ____

9. Remarks: ____

   ____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

|____|

Please place an "X" on the line above to indicate level of problem.

Therapist's Signature ______________________________________ Date _____________