Personal History

Date: _____________

Name ____ Email ____________________________

Age______________________ Date of birth ______________ Gender ______________________

Cell phone ________________ Work phone ______________ Home phone __________________

Is it okay to text or email you regarding appointment scheduling? ☐ Yes ☐ No

List members of your household and indicate whether they are roommates or family members:

____

History of legal problems: ____

How did you learn of my services? ____

Therapy

Presenting problem:

History of problem:

Satisfaction with life:

Describe any attempts/thoughts to harm yourself or others:

Previous therapy experiences:

Goals you may have for therapy:

Education/Occupation

Education completed:

Current area of study:

Current employer: Work satisfaction:

Activities and interests:

Family History

Relationship status: ____________________Total years together: _________ Years married: _________

Partner's name: ____ Age: ________

Partner's occupation: ____

Previous marriages or significant relationships:

Satisfaction with current relationship:

History of relationship trauma:

If you have children, list names and ages:

Mother's name: ____________________________________ Age: __________

Describe your mother and your relationship with her:

Frequency and form of communication:

Father's name: ______________________________________ Age: _________

Describe your father and your relationship with him:

Frequency and form of communication:

Siblings (names, ages, and significant information):

Childhood difficulties or traumas:

Provide any additional information or concerns that you would like for me to know:

Family Mental Health History

Indicate whether there is a family history of the following. If yes, please identify which family member (for example, brother, mother, grandmother).

			List Family Member(s)
Anxiety	☐ Yes	☐ No	________________
Depression	☐ Yes	☐ No	________________
Obsessive Compulsive	☐ Yes	☐ No	________________
Schizophrenia	☐ Yes	☐ No	________________
Bipolar	☐ Yes	☐ No	________________
Suicide Attempt	☐ Yes	☐ No	________________
Domestic Violence	☐ Yes	☐ No	________________
Obesity	☐ Yes	☐ No	________________
Eating Disorders	☐ Yes	☐ No	________________
Alcohol/Substance Abuse	☐ Yes	☐ No	________________

Medical

Describe your physical health:

Physician(s): ____

List current medications (including psychotropic and side effects):

List any allergies:

Identify use of the following:

	Past	Present		Past	Present	
Tobacco	☐	☐	Marijuana	☐	☐	
Caffeine	☐	☐	Cocaine	☐	☐	
Alcohol	☐	☐	Other	☐	☐	________________

If you use presently, please describe the frequency and amount of use for each substance:

____

Have you taken prescription painkillers/sedatives other than as prescribed? ☐ Yes ☐ No

If yes, please explain: ____