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Personal Information (Adult) – Psychotherapy

Name:______________________________ Date of Birth: ______________ Age:____________
Address: ____(city)________________ (state) ______ (zip) __________
Home phone:_______________________ Cell: ________________________ Work: ______________________
Email address: ____ SS#: ________________________

Occupation: ________________________ Employer: ____
Work address: ____

Current Relationship Status: ____
Name of Spouse/Partner/Significant Other: ____________________________ Date of Birth: ________________
Email address: ____ Phone: ______________________
Occupation: ________________________ Employer: ____
Work address: ____ Work phone: ________________

Do you have any children? __________ If yes, please identify:
Name: ________________________ M/F Date of Birth: _______________ Age: ____ Grade in School:___
Name: ________________________ M/F Date of Birth: _______________ Age: ____ Grade in School:___
Name: ________________________ M/F Date of Birth: _______________ Age: ____ Grade in School:___
Name: _________________________M/F Date of Birth: _______________ Age: ____ Grade in School:___

Primary Physician: ____ Phone: ______________________
Address: ____ Fax: ________________________
Date of last physical exam: _____________ Email: ____

Referred by: ____ Relationship: _______________
Address: ____ Phone: ______________________
Email: ____

Why are you coming in for treatment at this time? ____
____
____
____
____

How long have you experienced your current problem(s)? ____

What is the most important goal(s) you want to achieve during these sessions? ___________________________
____
____
____

Please list any major stresses you have experienced in the past five years: _______________________________
____
____
____

Have you had any trouble with the law? _____ If yes, please describe in detail: __________________________
____
____
____

Do you have a driver's license? ______ If yes, have you received traffic tickets and/or been in car accidents?
____
____

Do you have problems with your temper? ______ If yes, please describe in detail: ________________________
____
____

Have you ever lost your temper to the point you hurt someone or damaged property? _______ If yes, please describe in detail: ____
____
____
____

Have you seen a therapist or psychiatrist before? _______ If yes, please provide the following:
When/where in treatment: Type/Length of Treatment: Outcome (i.e. was it helpful?)
____
____
____

Medical History

Have you had any serious or chronic illnesses? _______ If yes, please describe in detail: __________________
____
____
____

Have you had any surgeries? ______ If yes, please describe in detail: __________________________________
____
____

Do you suffer from allergies? ______ If yes, please describe in detail: _________________________________
____
____

Do you have any hearing or vision problems? ______ If yes, please describe in detail: ____________________
____
____

Are you currently taking any medication (prescribed or over-the-counter)? _______ If yes, please provide the following information:

Medication Dose Frequency Prescribing Doctor

____
____
____
____
____
____

How much alcohol do you consume in a week? ____

Have you ever used drugs recreationally? _______ If yes, please describe type, frequency and date of last use:
____
____

Have you ever misused prescription or over the counter drugs? ________ If yes, please describe type, frequency and date of last use: ____
____
____

Family History

Do you or any members of your family experience: You/ Family Member(s):

Problems with anxiety: ______________ ____

Problems with depression: __________ ____

Alcohol/substance abuse: ___________ ____

Psychiatric illness: _________________ ____

Trouble with the law: _______________ ____

Seizures/Other neurological problems:_ ____

Tourette's syndrome/tic disorders: ____ ____

Thyroid problems: __________________ ____

Attention problems: _________________ ____

Learning disabilities: ________________ ____

Eating disorders: ___________________ ____

Physical abuse: _____________________ ____

Sexual abuse: ______________________ ____

Emotional abuse: ___________________ ____

Family relationships:

Parents: Age: Alive/deceased: Cause of Death: Quality of your relationship:
____
____

Siblings:	Age:	Alive/deceased:	Cause of Death:	Quality of your relationship:

Please provide any additional information/issues you want me to be aware of as we begin working together: