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CONFIDENTIAL PATIENT INFORMATION

General Information

Name _____

Date of Birth _____

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

Address _____

City _____ Zip _____

Parent/Guardian if Minor _____

Emergency Contact _____

Relationship _____

Phone _____

Names and ages of people living with you

Educational Level _____

Occupation _____

Cultural Heritage _____

Spiritual Orientation _____

Sexual Identity/Preference _____

Special Interests/Hobbies _____

Personal Strengths/Talents _____

Areas of Concern / Goals

What issues / concerns caused you to seek therapy?

What specific goals do you have for therapy?

Please describe any concerns / fears about therapy

Have you ever had a bad experience in therapy? _____

If yes, describe _____

Insurance Information

Name of Insured _____

Date of Birth _____

Insurance Provider _____

Provider Phone # _____

ID Number _____

Group Number _____

Patient Name: _____

Therapeutic History

Have you had therapy before? _____ When? _____
For how long? _____ What was the focus of therapy?

Were you ever subjected to verbal, physical, emotional,
or sexual abuse? _____

Have you ever been the victim of a violent crime? _____
If yes, please describe _____

Have you ever attempted suicide? _____ When? _____
Describe circumstances that led to the attempt(s) _____

Are you currently having any suicidal or murderous
thoughts? _____ If yes, please describe the thoughts

How many times per day/week do you have the
thoughts? _____

Medical History

Have you ever been diagnosed with a serious physical
illness? _____ If yes, please describe _____

Do you have any medical conditions that may affect
your therapy? Please describe _____

Please describe your overall health today _____

Are you experiencing any physical symptoms you
attribute to an emotional or stress related condition?

Have you ever been hospitalized for psychological
problems? _____ When? _____

For how long? _____

Why were you hospitalized? _____

What prescription medications are you taking? _____

Prescribed by whom? _____

Have you ever taken medication for a mental or
emotional condition? _____ When? _____

Physician / Phone _____

Psychiatrist / Phone _____

Family of Origin History

Mother's name / Age _____

Living / Deceased? Age at time of her death? _____

Cause of death? _____

Briefly describe your relationship with your mother

Father's name / Age _____

Living / Deceased? Age at time of his death? _____

Cause of death? _____

Briefly describe your relationship with your father

Names and ages of siblings _____

Briefly describe your childhood _____

Please feel free to include any other information that
you believe is relevant to your therapy _____

Patient Name _____

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	None	Mild	Moderate	Severe	How Long?
Sadness or Depression	0	1	2	3	_____
Suicidal Thoughts	0	1	2	3	_____
Persistent Thoughts About Death	0	1	2	3	_____
Sleep Problems	0	1	2	3	_____
Appetite Change	0	1	2	3	_____
Weight Change	0	1	2	3	_____
Difficulty Concentrating	0	1	2	3	_____
Compulsive Behaviors	0	1	2	3	_____
Obsessive Thoughts	0	1	2	3	_____
Intrusive Thoughts	0	1	2	3	_____
Flashbacks	0	1	2	3	_____
Nightmares	0	1	2	3	_____
Tension / Anxiety	0	1	2	3	_____
Panic Attacks	0	1	2	3	_____
Nervous in Crowds	0	1	2	3	_____
Difficulty Being Alone	0	1	2	3	_____
Memory Problems	0	1	2	3	_____
Hostile / Angry Feelings	0	1	2	3	_____
Violent Acts	0	1	2	3	_____
Social Isolation	0	1	2	3	_____
Strange Thoughts	0	1	2	3	_____
Sexual Problems	0	1	2	3	_____
Other _____	0	1	2	3	_____

Alcohol Use: never 1-4 times/month 2-3 times/week daily How long? _____
Consumption 1-2 drinks/sitting 3-4 drinks/sitting 5 or more
Intoxication never 1-4 times/month 2-3 times/week daily
Substance Use: none marijuana sedatives stimulants
opiates cocaine hallucinogens
caffeine nicotine other _____

Frequency: never _____times/daily _____times/weekly _____times/monthly How long? _____

Do you or anyone in your family have a history or alcohol or substance abuse? _____

Was there treatment? _____

Have you ever been in a 12-step Program? Please describe _____

Have you ever been arrested? _____ If yes, When/Why _____