**Patient Information**

Full Name:________________________ Preferred Name:__________ Age:________

Address:_____________________________________ City:__________State:_______ Zip__________

Phone: (H)_______________________(W)________________________(C)__________________________

Birth Date:______________________ SSN:______________________

Occupation:_____________________________________________________________________________

Employer:_______________________________________________________________________________

Emergency Contact:_______________________________ Phone:____________________________

Name of Insurance:_______________________________ Policy ID:__________________________

Group ID:_______________________________________

Whom may we thank for your visit today:____________________________________________________

**Personal History:**

Relationship Status: (Circle all that Apply):

Single Dating Married Since________ Partnered Since_________

Divorced Since_______ Widowed Since________ Separated Since_________

Other important relationship information: (i.e. gender identification, sexual orientation, chemical dependency, etc.)

______________________________________________________________________________________

______________________________________________________________________________________

Spouse/Partner or significant other's name: _______________________________________

Any Children: YES NO Step-Children: YES NO

Names and Ages:_________________________________________________________________________

Who lives in your home:_________________________________________________________________

Please rate the level of stress you feel at home:
1=No Stress 10=Very High Stress
1 2 3 4 5 6 7 8 9 10

I have: (circle one) No Friends A Couple Close Friends A Few Friends Lots of Friends

I have a difficult time making friends: YES NO

Activities or hobbies that you enjoy:____________________________________________________

**Military History**

Have you ever served in the military? YES NO Branch:________________________

**Religious affiliation or Spiritual Beliefs:**

______________________________________________________________________________

**School:**

Are you currently enrolled in school: YES NO Grade or Level:___________________

Name of School:_________________________________________

Please rate the level of stress you feel at school:
1=No Stress 10=Very High Stress
1 2 3 4 5 6 7 8 9 10

**Medical History:**

Are you currently receiving medical treatment? YES NO Explain:

______________________________________________________________________________
______________________________________________________________________________

Have you ever had a serious injury or illness? YES NO Explain:

______________________________________________________________________________
______________________________________________________________________________

Have you ever experienced a traumatic or life-endangering experience? YES NO Explain:

______________________________________________________________________________
______________________________________________________________________________

**Medical History (continued)**

Y N Are you currently taking medications? If so, please list:___________________________

Y N Have you ever had a serious head injury?

Y N Have you ever had previous therapy? ___Individual ____Group ____Couple

Y N Hospitalized for psychiatric reasons?

Y N Have you ever thought about suicide? If yes, date of most recent thought:__________

If yes, do you have a plan?

Y N Have you ever attempted suicide? Date(s):__________________________________

Y N Have you ever abused alcohol or other substances?

Y N Do you feel as if you have any type of addiction? Type:______________________

Y N Have you ever had difficulty sleeping?

Y N Have you ever had difficulty controlling your eating?

Y N Do you think you are at risk for HIV/AIDS?

Y N Do you ever recall being: ___Physically Abused ___Sexually Abused

___Verbally Abused ___Raped ___Emotionally Abused

**Family History:**

Mother's Name____________________ Living Deceased Age:_______

Father's Name_____________________ Living Deceased Age:_______

Parents are: ____Married ____Divorced ____Separated

Number of siblings:_______

Names/Ages:

___________________________ Where are you in birth order?_____________________

___________________________

___________________________

___________________________

**Family History (continued)**

Are you currently experiencing problems with any family members? YES NO

If yes, briefly explain:

___________________________________________________________________________

___________________________________________________________________________

Please rate the level of stress you feel, regarding family interaction:

1-No Stress 10=Very High Stress

1 2 3 4 5 6 7 8 9 10

Briefly explain the nature of the problem which has currently motivated you to seek help:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**I would like to learn more about, or need assistance with:** (circle all that apply)

| | | |
|---|---|---|
| **Abuse** (Physical, Sexual, Etc) | **Gender Identity** | **Stress** |
| **Anger** | **Grief or Loss** | **Solving Problems at Home** |
| **Anxiety** | **HIV/AIDS** | **Solving Problems at Work** |
| **Attention Deficit Disorder**(ADD) | **Medical Illness** | **Solving Problems at School** |
| **Behavior** | **Mood Disorder** | **Solving Problems with a Friend** |
| **Conduct Disorder** | **Nightmares** | **Solving Problems with Family** |
| **Depression** | **Obsessive Behavior** | **Substance Abuse** |
| **Divorce Issues** | **Phase of Life Problems** | **Alcohol Abuse** |
| **Drug Use** | **Phobias or Fears** | **Aging Issues** |
| **Ethnicity** | **PTSD** | **Death and Dying** |
| **Gambling** | **Relationship Issues** | **Major Life Change** |
| **Eating Disorder** | **Sexual Orientation** | **Self Esteem Issues** |

**Are there any other topics you would like to discuss, that were not listed?**________________________