Patient Information

Date:_____ Patient #_____ Therapist:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ May we contact you by e-mail if necessary? _____

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 (include dates): _____

_____

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: _____

_____

_____

Patient Name: _____ Date: _____

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?_____ If yes, what is the frequency and type of 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:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

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

_____

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

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

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?

_____

_____

_____

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 _____