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PATIENT BACKGROUND FORM

Today's date: ________________

Your name: ____
Last First Middle Initial

Date of birth: ______________________ **Place of birth** _______________________

What are your concern(s)? ____
____
____

What are your goals for therapy? ____
____
____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? ______________________________

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses: ________________________
____
____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? ____________________
Do you consume caffeine? YES NO If YES, how much per day? ____________________
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _______________
____

Previous Hospitalizations: (Approximate dates and reasons):________________________________
____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): ____
____
____

FAMILY

How would you describe your past and present relationship with your mother?
____
____
____

How would you describe your past and present relationship with your father?
____
____
____

Are your parents still married?______________ If they divorced, how old were you when they separated or divorced, and how did this impact you? ____
____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: ______________________________________
____

How many sisters do you have? ______ Ages? ____
How many brothers do you have? ______ Ages? _______________________________________
How would you describe your relationships with your siblings? _________________________
____
____

RELATIONSHIP STATUS

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: (POOR) 1 2 3 4 5 6 7 (EXCELLENT)
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships______________________
Do you have children? ___ If YES, how many and what are their ages:______________________
Describe any problems any of your children are having: ___________________________________

EDUCATION

Attending school now? _____ If YES, name of school: ___________________________
Degree or diploma held: ___________________ Last school attended: __________________
What is/was your experience of school/college: ____
____
____

LEGAL ISSUES

Have you ever been convicted of a crime? ___ Yes ___No
If yes, please describe ____
____
Have you ever been incarcerated? ___Yes ___No
If yes, please describe the location and length of incarceration(s)___________________________
____

Any additional information you would like to include:
____
____
____
____

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AREAS OF DIFFICULTY

Check all that apply. CIRCLE the main issue.

Difficulty with:	**Now**	**Past**	**Difficulty with:**	**Now**	**Past**	**Difficulty with:**	**Now**	**Past**
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friends			Diarrhea		
Fears			Co-workers			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in Joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills / Hot Flashes		

FAMILY HISTORY

Check all that apply.

- ☐ Drug / Alcohol Problems
- ☐ Legal Trouble
- ☐ Domestic Violence
- ☐ Suicide
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Hyperactivity
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Anxiety
- ☐ "Nervous Breakdown"
- ☐ Psychiatric Hospitalization