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SELF-REPORTED PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____

Why are you seeking therapy at this time?: _____

_____

_____

What is happening that makes this a problem for you?: _____

_____

_____

What is/are your goals for treatment?: _____

_____

ACADEMIC/EMPLOYMENT

Employment/School: _____

_____

Language Preference: _____ Reading Level: _____

Academic History (Include background, future possibilities):

_____

_____

Vocation History (include jobs, vocation preference, interests, and goals, financial issues):

_____

_____

_____

RELATIONSHIP STATUS

Support: ❑ Spouse ❑ Partner ❑ Nuclear Family ❑ Extended Family ❑ Close Friend ❑ Group of Friends ❑ Church/Mosque/Temple 12-step ❑ Service System

Available support for assistance in treatment if necessary? _____

_____

Family Situation/Living Environment/Status (Who is in the living environment? How would you describe it? Abuse occurring?):

_____

_____

If you are currently in a primary relationship, which of the following problems, if any, do you have with your partner (read the list and check those that apply): ❑Not apply

Conflict about money	❑	Conflict about children	❑	Conflict about lifestyle	❑
Conflict about sex	❑	Conflict about friends	❑	Conflict about substance use	❑
Conflict about employment	❑	Conflict about time together	❑	Conflict about friends	❑
Conflict about step-children	❑	Conflict about spouse's family	❑	Conflict about religious beliefs	❑
Other:	❑	Other:	❑	Other:	❑

Family of Origin: Members (Parents/Caretakers, Siblings):

Parents, Caretakers, Siblings	Age	Current Relationship: (1)Regular Contact (2)Irregular Contact (3)No Contact	Living (L) Deceased (D)

Children:

Children	Age	Current Relationship: (1)Regular Contact (2)Irregular Contact (3)No Contact	Living (L) Deceased (D)

MEDICAL HISTORY

Current Physical Problems/Disabilities/Conditions: No ____ Yes ___ _____

_____

_____

Family Medical History:

Condition	Relationship (mother, father, etc.)

Pregnant: ☐ Yes ☐ No ☐ N/A Need for Prenatal Care: ☐ Yes ☐ No ☐ N/A

Past Physical Problems/Conditions: _____

_____

Pain Level (1-10) ____Type (aching, throbbing, etc.)_____

Reason:_____

Highest Pain Level (1-10):_____ Reason_____

How was it treated (Medicines, therapy):_____

_____

Current Medications/Treatments: No ____ Yes ___ _____

_____

_____

Hospitalizations in Past 3 Years: No ____ Yes ___ When and why? _____

_____

_____

PSYCHIATRIC HISTORY

Previous Outpatient Treatment: No ___ Yes ___:

Clinician/Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Clinician/Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Clinician/Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Inpatient Treatment: No ___ Yes ___

Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Facility: _____ Date Range _____

Diagnosis: _____ Successful Completion: ☐ Yes ☐ No

Psychological Testing: No ___ Yes ____

If yes, by whom and when: _____

_____

Psychiatric Medications: No ___ Yes ___

Medication	Dosage	Current/Past	Effective Y/N

Family Psychiatric History: No ___ Yes ___ (Who and what is the diagnosis? Depressed? Anxiety?, etc)

_____

_____

SUBSTANCE USE/ABUSE HISTORY

Substance	Quantity	Frequency	Length of Time	Date of Last Use

Use of Community Resources (AA, shelters, halfway house)_____

_____

NUTRITION HISTORY

Do you eat 2 meals or less per day? _____No _____Yes How many? _____

Do you have to follow a specific diet due to illness? ___No___Yes Specify:

_____

_____

Do you have a history of binging/purging/restricting/use of laxatives?_____

_____

Do you eat fast food more than twice per week? ___No ___Yes How often?:

_____

OTHER

Is there anything else you would like your clinician to know? _____

_____

_____

_____

_____

_____

_____