

FAMILY HISTORY

Where were you born and raised? _____

Please list first names and ages of Brothers and Sisters:

First Name	Age	Relationship (natural, step, half)	Deceased? Y or N	Year?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check all information which applies to your parents:

Mother's 1st Name _____ Father's First Name: _____

<input type="checkbox"/> living -	Current Age: _____	<input type="checkbox"/> living -	Current Age: _____
<input type="checkbox"/> deceased	_____ year	<input type="checkbox"/> deceased	_____ year
<input type="checkbox"/> married	<input type="checkbox"/> divorced _____ # of times	<input type="checkbox"/> married	<input type="checkbox"/> divorced _____ # of times
<input type="checkbox"/> remarried		<input type="checkbox"/> remarried	

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?

Describe your relationship with your mother while growing up: _____

Current relationship with your mother? _____

Describe your relationship with your father while growing up: _____

Current relationship with your father: _____

HEALTH HISTORY

Please list any health problems:

Please list current: Medications/Supplements Dosage Condition for which it was prescribed:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Doctor's Name & Phone Number: _____

Do you smoke? _____ If so, how much a day/week? _____

Do you use recreational drugs? _____ If so, what kind and how often? _____

Do you use alcohol? _____ If so, how much a day/week? _____

Ever attended outpatient/inpatient chemical dependency treatment? _____ If so, when? _____

Any pending legal issues? _____

Sleep issues? _____ Please describe: _____

Appetite/weight issues? _____ Please describe: _____

Please describe the problem that has brought you to see me:

LEARNING NEEDS & SENSITIVITIES:

Please check those that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Math difficulty |
| <input type="checkbox"/> Asperger's | <input type="checkbox"/> Reading or writing problems |
| <input type="checkbox"/> Sensitivity to light, sound, smells | <input type="checkbox"/> Auditory processing problem |
| <input type="checkbox"/> Had special education classes in school (IEP) | <input type="checkbox"/> Other: _____ |

SPECIFIC CONCERNS:

Please check any that apply to you NOW. Put a "P" by any that occurred in the PAST:

- | | | |
|---|---|--|
| <input type="checkbox"/> Abuse (spouse/partner) | <input type="checkbox"/> Grieving/Losses | <input type="checkbox"/> Panic/Anxiety Attacks |
| <input type="checkbox"/> Alcohol/Drug abuse | <input type="checkbox"/> Headaches/Pains | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Health/Illness/Medical | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Anxiety/Stress | <input type="checkbox"/> Internet problems | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Childhood abuse | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Poor Self-care |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sexual issues/conflicts |
| <input type="checkbox"/> Cutting/Self-injury | <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Smoking/Tobacco use |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Motivation/Laziness | <input type="checkbox"/> Low frustration tolerance |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Tension/Nervousness | <input type="checkbox"/> Weight & diet issues |
| <input type="checkbox"/> Fears/Phobias | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Withdrawal/isolating |
| <input type="checkbox"/> Gambling problem | <input type="checkbox"/> Oversensitive to rejection | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Gender identity concerns | | |

How did you hear about my services? Psychology Today Web Referred by: _____

What are your goals for seeking treatment at this time? _____

Client Signature

Today's Date