Present and History Name/Date _____

What brings you to therapy? _____

_____

_____

_____

When do you believe your concerns began? _____

Have you ever engaged in therapy prior (If so, when/where)? _____

_____

What have you done to solve your present concerns? _____

_____

What are your strengths? _____

_____

What are your goals for improvement? _____

_____

Where do you get support?

_____

_____

Describe your drinking of alcohol? (# days a week & how many per occasion) _____

_____

Describe any other drug use?

_____

_____

Have you ever been treated for an inpatient stay at a hospital for mental health or alcohol/other drug use?

If so, when and where? _____

_____

_____

Do you have any knowledge of family history of mental health concerns or alcohol/drug use? _____

_____

_____

Health Information

Psychological factors can affect health directly.
To help me understand you and your concerns I ask you to provide the information below.

How would you rate your present health? _____ Excellent _____ Good _____ Fair _____ Poor

Physician Name _____ Address _____

Physician Phone # _____ Date of last visit? _____

What current physical symptoms/ concerns are you experiencing? _____

_____

How would you describe your diet? _____

How are you sleeping? _____

Are you a smoker, if yes, daily amount? _____

Do you exercise, if yes, please describe? _____

Have you ever had thoughts of hurting yourself or an attempt? _____

_____

Please check if you or a family member has any of the following:

	You	Family		You	Family
Alcoholism	___	____	Blood Problems	___	____
Arthritis	___	____	Anorexia/Bulimia	___	____
Cancer	___	____	Sexual Abuse	___	____
Cirrhosis	___	____	Physical Abuse	___	____
Diabetes	___	____	Physical Disability	___	____
Allergies	___	____	Developmental Disability	___	____
Asthma	___	____	Multiple Sclerosis	___	____
Seizures	___	____	Blood Pressure	___	____
Heart Issues	___	____			

If there are other self/family health concerns not mentioned above please share: _____

_____

Please list medications you are on presently:

Med:_____ Dosage: _____ Med: _____ Dosage: _____

Med:_____ Dosage: _____ Med: _____ Dosage: _____

Med:_____ Dosage: _____ Med: _____ Dosage: _____

Signature _____ Date _____