Kathy Lucy, LMFT

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PERSONAL HISTORY FORM

Name _____ Gender: M F T
(Last) (First) (Middle/Maiden)
Birth date _____ Age _____ Social Security # _____

Phone (home)_____ OK to call? Yes No OK to leave message? Yes No
Phone (work)_____ OK to call? Yes No OK to leave message? Yes No
Phone (mobile)_____ OK to call? Yes No OK to leave message? Yes No
E-mail Address: _____ OK to use? Yes No
Address _____
_____

Note: Some individuals share voicemail or email with others and would prefer not to have messages left.

Highest Educational Level or Degree Attained _____
Occupation and Place of Employment/School _____
Annual/monthly income: _____

Referred by: _____
May I have your permission to thank this person for the referral? _____ Yes _____ No
(no additional information will be shared with this individual)

Person to contact in case of emergency:
Name _____ Relation _____
Phone (home) _____ Phone (work) _____ Phone (mobile) _____
Address _____
_____

With whom do you live: (check all that apply)
____Alone ____ Partner/Spouse ____ Roommate(s) ____ Parent(s) ____ Child(ren)
____ Sibling(s) ____ Friend ____ Others _____

Relationship status: (check one)
____ Single ____ Married ____ Engaged ____ Separated ____ Divorced ____ Widowed
____ Remarried (number of times ____)

Partner/Spouse's Occupation _____ Partner/Spouse's Age _____
Number of Children _____ Ages and Sex _____
Number of Step-Children _____ Ages and Sex _____

FAMILY HISTORY

Please check all those with whom you lived while growing up:
____ both biological parents ____ adoptive parents
____ mother & stepfather ____ single parent (which?) _____
____ father & stepmother ____ other relatives (which?) _____
____ other (describe) _____

Mother: Name_____ Age: ____ Occupation: _____
If deceased, how old was she? _____ How old were you? _____
Father: Name_____ Age: ____ Occupation: _____
If deceased, how old was he? _____ How old were you? _____
List age and sex of sisters and brothers: _____

HEALTH HISTORY

Previous psychotherapy, counseling, assessment, or hospitalizations:
Dates: _____
Provider (s): _____
Primary issue(s): _____
Medications: _____

Have you had a history of heavy alcohol or drug use? _____ Yes _____ No
If yes, please explain: _____
_____

What is your current consumption of:
Alcohol_____ per_____; Caffeine _____ per_____; Cigarettes_____ per _____
Cocaine _____ per _____; Sugar _____ per _____ ; Marijuana _____ per _____
Other substances: _____
Do you want to change the use of any of these substances? _____

Current Medical Problems _____
Current Medications _____
Nature and date(s) of previous significant medical problems:
_____
_____

Name and Address of Physician and/or Psychiatrist_____
_____
_____

Have you ever attempted suicide? _____ Yes _____ No If so, at what age(s) _____
Do you feel suicidal at this time? _____ Yes _____ No
Have any of your relatives or loved ones attempted or committed suicide? _____ Yes _____ No
If yes, when & relation to you _____

Has anyone in your family been treated for a psychiatric disorder? _____ Yes _____ No
If yes, relation to you and type of treatment received: _____
_____

Has anyone in your family had a history of heavy alcohol or drug use? _____ Yes _____ No
If yes, please explain: _____
_____

MILITARY HISTORY

List military experience (include dates of service and type of discharge): _____
_____

CLINICAL INFORMATION

Briefly state why you are seeking psychotherapy at this time: _____
_____
_____
_____
_____

How long have you been troubled by these issues? _____
How long do you expect therapy to last? _____
Do you consider the severity of your problem(s) to be:
____ Mild ____ Moderate ____ Severe ____ Extreme ____ Incapacitating