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Information Form

Except in cases of child abuse or immediate danger to yourself or others, all information you provide on this form will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

PERSONAL INFORMATION:

NAME: _____ DATE: _____

ADDRESS: _____

PHONE (CELL): _____ (HOME): _____ (WORK): _____

EMAIL _____

Please check the corresponding boxes below to indicate that it is okay to contact you by this means:

☐ cell phone ☐ cell text ☐ home phone ☐ work phone ☐ email ☐ mail

AGE _____ and DATE OF BIRTH:_____

ETHNIC BACKGROUND: _____RELIGION: _____

HIGHEST GRADE OF EDUCATION: _____

WHO REFERRED YOU? Individual: _____ Website: _____
Agency: _____ Other: _____

PRESENT MARITAL STATUS: ___Single ____Living together ___Engaged ___Married
___Separated ___Divorced ___Remarried ___Widowed

SPOUSE/PARTNER'S NAME: _____ AGE:_____

SPOUSE/PARTNER'S RELIGION: _____

SPOUSE'S HIGHEST GRADE OF EDUCATION: _____

Number of years married/living together: _____

Were there any previous marriages for either spouse: _____ How many? _____

Husband: ____ Duration of each; _____ Wife: _____ Duration of each: _____

WHO IS LIVING IN YOUR RESIDENCE? (Use back of sheet if needed.)

Name:	Age:	Relationship:

CHILDREN NOT LIVING AT HOME (Use back of sheet if needed.)

Name:	Age:

MEDICAL HISTORY:

Family Physician's Name: _____ Phone: _____

Location (City, State): _____

Do you or anyone in your family have any known medical problems, either current or past?
If yes, please describe:

_____

_____

Are there any health related issues you think your therapist should know about? _____

_____

Are you or anyone in the family currently taking any medications?_____ If yes, please list,
Medications:_____
Dosage:_____

Medicating Physician or Psychiatrist:_____ Phone:_____

FAMILY HISTORY:

Have there been any deaths in the immediate family? Please list by name and relationship and identify when these occurred.

_____

_____

_____

Has anyone in your family or your partner's family ever attempted suicide? If yes, please explain.

_____

_____

Has anyone in your family ever expressed concern about another family member's use of alcohol or drugs? Please explain.

_____

_____

Do you regularly: (If so, how much and how often?)
Drink: _____Smoke: _____

Use prescribed or non-prescribed drugs?_____

If you do, does your habit hurt your relationships with others? _____

Does it hurt your job? _____

Is it difficult for you to stop or control the amount you take? _____

Has anyone ever expressed concern about the way in which anger is managed in your family? If yes, please explain or give example(s).

_____
_____
_____

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, punching. If yes, please explain: _____
_____
_____

Is there any history of violence, verbal or sexual abuse in your family? _____
_____

WHY YOU'RE HERE:

Please describe briefly the most important problems for which you would like help:

_____
_____
_____

On a scale of 1 (mild) to 5 (severe), how would you rate your current problem? _____

How long has this been a problem? _____

How have you tried to correct this problem in the past? _____
_____
_____

Has anything changed since you made the decision to seek help? _____
If yes, what? _____

Have you had counseling or therapy in the past? _____
If yes: Therapist? Reason for treatment? When was this? Was it helpful?

_____
_____
_____

In case of an emergency, whom can I notify?
Name:_____ **Relationship:**_____
Address: _____
Phone: Home:_____ **Work:**_____

Thank you for taking the time to complete this form.