lmftl478@rhondamariestalblmft.com
(256) 203-6775

Basic Information:

Date:____

Patient Name:____

Social Security Number: ________________________________

Date of Birth:____

Gender: ☐ Male ☐Female

Ethnicity:____

Home Address: _______________________________________

Home Phone Number: ___________________________

May we leave a message? ☐ Yes ☐No

Work Phone Number: ___________________________

May we leave a message? ☐Yes ☐No

Mobile Phone Number: __________________________

May we leave a message? ☐Yes ☐No

If the above patient is a minor complete the following:

Name of

Guardian:____

Address of

Guardian:____

Guardian's Home

Phone:____

May we leave a message? ☐ Yes ☐No

Guardian's Work Phone:

May we leave a message? ☐ Yes ☐No

Guardian's Mobile Phone:

May we leave a message? ☐Yes ☐No

Referral Source:____

Emergency Contact Information

In case of an emergency, who should we contact?

Name:____

Relationship:____

Address:____

Phone Number:____

History Information

Who is providing the history information?

☐The patient

☐The patient’s guardian

☐Other

Please describe the current complaint or problem as specifically as you can, in your own words.

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

☐Substance abuse/dependence

☐Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.

☐Depression/Sad/Down feelings

☐High/Low energy level

☐Angry/Irritable

☐Loss of interest in activities

☐Difficulty enjoying things

☐Crying spells

☐Decreased motivation

☐Withdrawing from people/Isolation

☐Mood Swings

☐Black and white thinking/All or nothing thinking

☐Negative thinking

☐Change in weight or appetite

☐Change in sleeping pattern

☐Suicidal thoughts or plans/Thoughts of hurting yourself

☐Self-harm/Cutting/Burning yourself

☐Homicidal thoughts or plans/Thoughts of hurting others

☐Poor concentration/Difficulty focusing

☐Feelings of hopelessness/Worthlessness

☐Feelings of shame or guilt

☐Feelings of inadequacy/Low self-esteem

[☐Anxious/Nervous/Tense feelings

☐ Panic attacks

☐Racing or scrambled thoughts

☐Bad or unwanted thoughts

☐Flashbacks/Nightmares

☐Muscle tensions, aches, etc.

☐Hearing voices/Seeing things not there

☐Thoughts of running away

☐Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

☐Feelings of frustration

☐Feelings of being cheated

☐Perfectionism

☐Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs

☐ Distorted body image (believe you are heavier or less attractive than others say you are)

☐Concerns about dieting

☐Feelings of loss of control over eating

☐Binge eating/Purging

☐ Rules about eating/Compensating for eating

☐Excessive exercise

☐Indecisiveness about career

☐Job problems

☐Other:

Explain:

Previous Treatment

Have you received or participated in previous counseling and/or therapy? ☐Yes ☐No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns? ☐Yes ☐No

Additional Information:

Are you currently experiencing thoughts of harming either yourself or someone else?

☐Yes ☐No

Have you in the past experienced thoughts of harming either yourself or someone else?

☐Yes ☐No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? ☐Yes ☐ No

If yes, explain:

Did you walk, talk, and read on time? ☐Yes ☐No

Explain:

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? ☐Yes ☐ No

Explain:

Are you satisfied at where you are in your life?

If not, where would you like to be?

Medical History

List any current or important past medications

Medication & Dose:

Response to Medication:

History of serious childhood illnesses:

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime:

Have you experienced any head injuries? ☐ Yes ☐No

Important Details:

If yes, did you lose consciousness? ☐Yes ☐ No

Have you experienced convulsions or seizures? ☐Yes☐ No

If yes, did you also have a fever? ☐Yes ☐No

Explain any allergies you have:

How would you rate your current physical health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐ Poor ☐Very Poor

What was the date of your last physical or routine health "check up?"

Do you have a primary care physician? ☐Yes ☐No

If yes, complete the following:

Name:____

Address:____

Phone Number:____

Family History

Birth Location: ____

Raised by: ☐Mother ☐Father ☐Step-Mother ☐Step-Father

☐Other:

Explain:

Relationship with Parent Figures

(good, fair, poor, close, distant, etc.)

Mother:____

Father:____

Step-parent:____

Other:____

List your siblings and describe your relationship with them?

Names:____

Ages:____

Genders:____

Birth Order:____

Nature of Relationship:

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

Any family history of substance abuse, mental illness, suicide, or violence?

Any Additional Family Information:

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History

When attending school where you:

☐In regular classes

☐Home Study

☐Special classes

☐Advanced classes

☐Ever suspended

☐Placed in alternative school

What is the highest educational level you have

completed?______________________________

Give any additional important educational information (i.e. Did you like school?

Have a learning disability?)

Occupational History

What is your current employment status?

☐Employed Full-Time

☐Employed Part-time

☐Unemployed

☐Self-employed

☐Student

☐Other

Are you satisfied with your employment?

If not, why?

Marital History

Which best describes your marital status?

☐Married, Date: ______

☐Never Married

☐Widowed, Date: _____

☐Separated, Date: _____

☐Divorced, Date:_______

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction? ☐Poor☐Fair ☐Good ☐Great

Please list any previous marriages/significant relationships including current:

Name:____

Date:____

Nature of Relationship

Do you have children? ☐Yes ☐No How many?____________________________________

If yes, complete the following:

First Names:____

Ages:____

Genders____

Nature of Relationship

Are there presently any child custody issues involving you or your family? ☐Yes ☐No

Does your family currently have Child Protective Services Involvement? ☐Yes ☐No

If yes please complete the following:

Case Worker's

Name:____

Phone:____

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (Alcohol, tobacco, Marijuana, caffeine, or other) ☐Yes ☐ No

If you answered yes, please complete the following substance abuse history information.

Age of First Use:____

Frequency of Use ☐Daily ☐Weekly ☐Monthly

Check each box that applies to your substance abuse history:
☐Alcohol ☐Marijuana ☐Cocaine or Crack ☐Heroin ☐Amphetamines ☐Club Drugs (Ecstasy, Inhalants, etc.) ☐Pain Medication (Oxycontin, Vicodin, etc.)

☐Benzodiazepines

☐Hallucinogens ☐Other:______________________________

Amount Used:____

How did you use it? (Smoked, injected, etc.) Explain:

Complete the following if you have ever received treatment for a substance abuse issue.

Name of Treatment

Program____

Name of Substance Abuse

Counselor____

Phone:____

____

Type of Treatment ☐Rehab ☐Intensive ☐Outpatient Program ☐Partial

Hospitalization

☐Halfway House ☐Recovery House ☐Counseling ☐Methadone ☐Suboxone

Date of Treatment (Month,

Year):____

Outcome (Any Clean time?) Explain:

Legal History

Do you currently have any pending criminal charges? ☐Yes ☐ No

Are you on probation? ☐Yes ☐No

Name of Probation Officer and

County:____

Have you ever been arrested/convicted of a crime? ☐Yes ☐ No:

If yes, complete the information below:

Arrests/Convictions:____

Date of Arrests/Convictions:____

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.) Explain:

Summarize your goals for counseling/therapy:

What expectations do you have for counseling/therapy?

Name 5 things you would like to change about yourself.

What are your strengths?

What are your weaknesses?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_________________________________ _________________________________

Signature of client or guardian Date