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Child, Adolescent, Adult & Family Therapist
DBA Hope Counseling Centers

PATIENT INFORMATION

Name:
Last _____First _____Middle_____

Today's Date: _____/_____/_____ □ Male □ Female

Date of Birth: _____/_____/_____ Age: _____

Physical Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home Phone _____ Work: _____ Cell/Alternate.: _____

Fax: _____ E-mail: _____

Employer: _____ Occupation: _____

Employer Address: _____ Telephone: ( ) _____-_____

EMERGENCY CONTACT
Name: _____ Relationship to you_____

Address: _____

Phone Daytime: _____ Evening: _____Cell/Alt: _____

REFERRED BY:
_____

Where were you born? _____What is your ethnic identity? _____

Religious preference:_____

Do you work at the present time?
_____No_____Yes, Full or part time? _____
_____Student, Full or part time? _____
_____Homemaker
_____Retired
_____Supported by savings, family, etc...
If you are employed, where do you work?_____
What is the nature of your work?
_____
How long have you been at your present job? _____
What were your previous jobs?
_____

What is the highest grade of school you completed?
_____

If you are a student, where do you attend school?

_____

List any major physical illness, hospitalizations, accidents that you have had and at what age they occurred:_____

_____

Have you had past psychiatric hospitalizations? _____Yes _____No
If yes, please state where and reason for hospitalization: _____

_____

What medications do you take? (include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies, including medication allergies/sensitivities:

_____

What recreational substances do you use / have you used in past, if any(please include alcohol and cigarettes)?

_____

How often do you use these substances (if not currently using, how often in past)?

_____

Do you consider any of your substance use to be a problem? _____ Yes _____ No
If yes, please describe:

_____

Are you having any problems with your sleep habits? _____ Yes _____ No
(If yes, circle where applicable)

Sleeping too little Sleeping too much Poor sleep Disturbing dreams Other

Use this space to describe sleep issues:

_____

How many times a week do you exercise? _____For about how long each time? _____

What type of exercise do you do? _____

Are you having any difficulty with appetite or eating habits? _____ Yes _____ No
(If yes, circle where applicable)
Eating less Eating more Binging Restricting Significant weight change

Do you have any problems or worries about sexual functioning? _____ Yes _____ No
(If yes, circle where applicable)

Lack of desire Performance Problem Sexual Impulsiveness Arousal Difficulties Other

What activities do you enjoy doing in your free time?

_____

Which of the following applies to you?

I am ___Single ___Married ___Partnered ___Divorced ___ Widowed ___ Other
_____ I am in a serious relationship and we live together
_____ I am in a serious relationship and we do not live together

Please list previous marriages and/or serious relationships.

_____

Please answer the following if you are with your partner now:

What is your partner's name? _____

What is your partner's occupation? _____

FAMILY BACKGROUND QUESTIONNAIRE

Please list the names and ages of your children, if any, including step-children.
Please note if your children are biological or adopted. If adopted, please note age when adopted. If any of them are deceased, please list date they were born and died:

_____
_____
_____
_____
_____

Are your parents alive or deceased? _____

Are your parents married or divorced? _____
If divorced, are either of them re-married? If so, whom?

_____
If divorced, what age were you at the time of the divorce? _____

How much is your immediate family a source of emotional support for you? (Circle one):

None Little Somewhat Substantial Very Strong

Besides family members who do you count on right now for friendship or emotional support? (please name and note relationship to you)

_____
_____

Please check any past or impending issues that apply to you, your parents and/or siblings?
Self, Mother, Father, Sibling(s), Other(specify)

	Self	Mother	Father	Sibling	Other

	Alcohol abuse					
	Drug abuse					
	Emotional problems					
	Psychiatric hospitalizations					
	Anxiety					
	Depression					
	Other mental illness					
	Ulcers or colitis					
	Asthma					
	Serious physical illness					
	Weight/eating problems					
	Anorexia					
	Bulimia					
	Insomnia					
	Attempted/ Completed suicide					
	Epilepsy					
	Physical Abuse					
	Sexual Abuse					
	Debilitating injuries/disabilities					
	Numerous					
	childhood					
	illnesses					
	Frequent relocations					
	Learning problems					
	Deaths					
	Divorce					
	Financial					
	crisis/unemployment					
	Legal problems					
	Other					

Please state in detail your present issues, how long they have persisted, and your reason for seeking treatment at this time (use as much space as you like. Feel free to write on back of this page).