CLIENT HISTORY FORM

Yvonne Marisa Doelling, MA, MHP, LMHC, ATR-P, CDBT
Outside the Line Counseling & Art Therapy
506 Second Ave, Suite 1400
Seattle, WA 98104
contact@arttherapybymarisa.com phone number: 206.305.0080

NAME: _____ Date: _____

Date of Birth : _____ Email: _____

Phone:_____(home/work/cell) Phone: _____ (home/ work/ cell)

(initial) _____ I authorize you to leave messages on the following phone: (home/ work/ cell)

Address: _____

Emergency Contact: _____ Phone: _____

Why are you here for treatment today? Please specify nature of problem, duration, frequency, severity:

_____

_____

_____

Medical History

1. Are you taking ANY type of medication currently?

Name of medication	Dosage	Reason	Date begun
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever taken any psychiatric medications in the PAST?

Name of medication	Dosage	Reason	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3.Do you have any chronic health problems

❒ asthma ❒ heart disease ❒ dementia

❒ diabetes ❒ sleep apnea ❒ _____

❒ chronic pain (please circle: fibromyalgia, chronic fatigue, TMD, IBS, arthritis, other: _____)

4. Do you have any of the following (please give details):

❒ Recurrent headaches : ❒ Migraine ❒ Tension ❒ Cluster ❒ other: _____

❒ recurrent stomach aches ❒ vision problems ❒ tremor, shakes, or jitters

❒ recurrent vomiting ❒ hearing problems ❒tics or other movement problems

❒ constipation ❒ weight loss or gain

❒other_____

5. In the last 6 months, have you noticed any change in:

❒ eating (circle: increase or decrease)
❒ sleeping (circle: increase or decrease)
❒ mood (circle: increase or decrease)
❒ doing more or less activities than I usually do
❒ enjoying myself more or less than I usually do

❒ feeling guilty or shameful
❒ feeling hopeless or helpless
❒ thoughts of harming yourself
❒ feeling restless/ aggitated
❒ feeling excessively anxious or worried

6. Have you or any of your biological relatives had the following conditions? Please check all that apply, past, or present.

	MOM	DAD	MOM'S FAMILY	DAD'S FAMILY	SIBLINGS	YOU
Mental Retardation						
Autism						
Learning problems						
Attention problems						
Hyperactivity						
Epilepsy						
Alcoholism						
Drug Abuse						
Depression						
Suicide Attempt(s)						
Self-harm (e.g., cutting)						
Anxiety Disorder						
Bipolar Disorder						
Schizophrenia						
Psychosis						
Criminal history						

Social History:

1. Please list members of household:

Household Member's Name **Age** **Relationship**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

2. What is your ethnicity? What are cultural/spiritual factors that most influence you?

_____

_____

3. Are you experiencing any unusual stressors? ☐ No ☐ Yes Please explain.

_____

_____

4. Have you experienced any recent losses? ☐ No ☐ Yes Please explain.

_____

_____

5. Have you ever intentionally hurt yourself or made a suicide plan or attempt? If so when was this?

_____

_____

6. Has anyone said you have a drugs or alcohol problem? ☐ No ☐ Yes Please explain.

_____

_____

7. Has anyone said you have an anger problem? ☐ No ☐ Yes Please explain.

_____

_____

8. Have you ever been in any conflicts that resulted in physical confrontation? For example: hitting, pushing, or pulling hair. ☐ No ☐ Yes Please explain.

_____

_____ Thank you for taking the time to complete this.