Background information

Person completing form: ☐self ☐ other: ________________________________

Name: _________________________________ D.O.B: _________________________________ Age: ____

Sex: ☐ Male / ☐ Female

Marital Status (check one)

☐ Single

☐ Married

☐ Divorced

☐ Separated

☐ Widowed

If married, length of current marriage: _______ Number of times married: ______
Number of children: _______

How many people live in your home? ______ please list these people below:

Name	Relationship to you	Age

What is your occupation? _______________________________ Spouse? ________________________

What are the major symptoms you are having problems with?

Symptom	At what age did this begin?	How frequently is this happening?

Fairhaven Counseling
746 Graham Rd.
Cuyahoga Falls, Ohio 44221

Highest level of education completed? __________________

Are your parents:

☐ Married

☐ Divorced you were how old? _______

☐ Separated you were how old? ______

☐ Widowed you were how old? ______

☐ Mother deceased you were how old? ______

☐ Father deceased you were how old? ______

Where were you raised (city/state)? _______________________ by whom? _________________

How many children were there in your family of origin? _________ what number are you? _________

How would you describe your relationship with your parents? ________________________________

How would you describe your relationship with your siblings? ________________________________

Please check any areas that were part of your childhood:

☐ Family member with chronic illness

☐ Death in the family

☐ Economic difficulties

☐ Alcohol/drug problems in the family

☐ Moved frequently

☐ Family violence

☐ Emotional abuse

☐ Sexual abuse

____ Mental

____ Physical

____ Sexual

____ Spiritual

☐ Other ______________________________

Family history: Please indicate the psychiatric problems that may exist among relatives that are biologically related. **Please include aunts, uncles, maternal & paternal grandparents. **

Disorder	Mothers	Father	Siblings	Other biological relative(please specify)

Medical Information:

Are you in: ☐ good health ☐ fair health ☐ poor health

Date of last examination? ______________________

Please check any of the following conditions/problems you have experienced in the last 18 months:

☐ Dizziness/ fainting
☐ Breathing difficulty
☐ Pain/stress
☐ Blackout/ Seizures
☐ Nausea/vomiting
☐ Frequent headaches
☐ Fatigue
☐ Recent weight change / weight gain / weight loss
☐ Difficulty concentrating
☐ Crying more easily
☐ Suicidal thoughts
☐ High blood pressure
☐ Migraines
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Hay Fever
☐ Arthritis
☐ Other ________________________________

☐ Shaking of hands, arms, or legs
☐ Frequency or difficulty in urination
☐ Chills
☐ Night sweats
☐ Lack of sleep / sleep disorder / trouble falling asleep
☐ Early morning awakening
☐ Loss of appetite
☐ Epilepsy or seizures
☐ Trauma to the head
☐ Psychiatric hospitalization
☐ Heart attack
☐ Mitral valve prolapse
☐ Rheumatic heart
☐ Stomach ulcer
☐ Colitis
☐ Leukemia
☐ Bleeding tendency
☐ Diabetes

Are you currently being treated by a doctor or taking medications prescribed by a doctor? ☐ Yes / ☐ No

If yes, state the problem(s) or condition (s) you are being treated for: _______________________
____

Physicians name: ______________________________ Telephone: ___________________________

What medications are you currently taking? (Please list)

Medication	Dosage	Prescribed by:	Length of time taken

Please list the conditions you have been treated for in the past:

Condition	Medication taken?	For how long?	Medication name(s)	Helpful?

Substance use: Please check and describe which of the following substances you are using or have used in the past:

Substance Use	Amount	Frequency	Age of first use	Date of last use
☐ Alcohol (beer, wine, whiskey, etc.)				
☐ Cannabis (marijuana, hash, etc.)				
☐ Opiates (LSD, PCP, acid, etc.)				
☐ Inhalants (Glue, gasoline, etc.)				
☐ Pain Killers (Vicodin, OxyContin, etc.)				
☐ Sedatives (Sleeping pills, Nerve pills, etc.)				

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Substance use	Amount	Frequency	Age at first use	Date of last use
☐ Stimulants (Crack, Cocaine, etc.)				
☐ Tobacco Products				
☐ Other				

Check all major areas affected by alcohol/drugs and describe below:

☐ Legal	
☐ Physical	
☐ Family	
☐ Marital	
☐ Social	
☐ Financial	
☐ Work	
☐School	

Have you ever felt, or been told you should cut down on your use of alcohol/drugs? ☐ Yes ☐ No
Please describe: ____

Have you recently been abusing or withdrawn from the use of alcohol, medication, or illegal drugs? ☐ Yes ☐ No. If yes how long? ____

Past hospitalizations: ☐ Yes☐ No. (If yes, please list them)

	Date	Reason	Hospital/Facility
Medical			
Psychiatric			
Chemical dependency			

Have you had previous counseling, received EAP services, or been treated for chemical dependency? If yes, please list below:

Facility	Date(s)	Reason	Helpful?