Beach Counseling Center LLC History

Name: _____ Date:_____

Allergies_____ Sex: _____ Date of Birth: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Unmarried Couple

MEDICAL HISTORY:

Name of Family Physician:_____ Phone # _____

Height: _____Weight: _____Date of last visit: _____

Reason for your visit today?_____

Medical Conditions: _____

Former Psychiatrist/Therapist: _____

Trauma History: _____

Family Psychiatric History: _____

Family History: _____

Educational/Occupational History: _____

Legal History: _____

Please check all that may apply:

- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Suicidal Thoughts
- ☐ Cutting/Self-mutilation
- ☐ Feelings of Sadness
- ☐ Feelings of worthlessness
- ☐ Feelings of emptiness / numbness
- ☐ Feelings of loneliness
- ☐ Loss of Interest in activities
- ☐ Uncontrollable crying spells
- ☐ Neglected hygiene / appearance
- ☐ Postpartum Depression
- ☐ Excessive shame or guilt
- ☐ Sleeping too much
- ☐ Inability to sit still
- ☐ Concentration
- ☐ Poor Grades
- ☐ Poor work performance
- ☐ Racing thoughts
- ☐ Indecisiveness
- ☐ Recurrent thoughts or worries
- ☐ Difficulty thinking / distractions
- ☐ Difficulties at work or school
- ☐ Poor memory
- ☐ Trouble getting along with others
- ☐ Avoiding people / Social Situations
- ☐ Outbursts of anger
- ☐ Defiant
- ☐ Oppositional Defiant Behavior
- ☐ Obsessive-Compulsive Disorder
- ☐ Feeling as if reliving past trauma
- ☐ Excessive fear of persons / places
- ☐ Feelings of doom or death
- ☐ Recurring distressing dreams
- ☐ Trauma
- ☐ Sexual Assault
- ☐ Post-Traumatic Stress Disorder
- ☐ Withdrawing or Isolating
- ☐ Recurring flashbacks
- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ DUI/DWI
- ☐ Alcohol Abuse
- ☐ Grief
- ☐ Death of Spouse/child

_____

Medications:

Medication	Dose	Reason

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