Deep Roots Family Therapy, LLC

History

Name: _____ **Age:**_____

Reason for visit:_____

_____

_____

Prior history of out-patient mental health treatment: **Yes / No**

If Yes, when:_____ **Where:**_____

Therapist/Provider Name: _____

Issues Addressed:_____

Have you ever been hospitalized for a mental health condition: **Yes / No**

If Yes, When: _____ **Where:**_____

Diagnosis:_____

Are you currently taking any over the counter or prescribed medication: **Yes / No**

If Yes, Please specify what medications you are taking and dosages: _____

_____

_____

Who prescribes your medications:_____

I use drugs or alcohol recreationally at present: **Yes / No**

If Yes, what do you use:_____ **How often:**_____

Has your use of drugs/alcohol ever caused job, relationship or legal issues for you:

Yes / No **Please explain:**_____

Have you ever been verbally, emotionally, sexually, physically abused: Yes / No

Please explain: _____

_____

In the past or present have you ever harmed yourself: **Yes / No**

Please explain:_____

Do you consider yourself a Christian? **Yes / No**

Do you presently attend church? **Yes / No** **If so, where?** _____

How interested are you in incorporating your faith into your treatment?

_____

_____

Additional topics of concern you hope to address:

_____

_____

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