

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

## IDENTIFYING INFORMATION

Name of person completing the form \_\_\_\_\_

*Last*

*First*

Relationship to the Client \_\_\_\_\_

Client's Name \_\_\_\_\_

*Last*

*First*

*Middle Initial*

Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Place of Birth \_\_\_\_\_

*(mm/dd/yyyy)*

*City/US State/Country*

Highest Level of Education \_\_\_\_\_

Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

Emergency Contact Person's Name \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL AND HEALTH INFORMATION

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_

Have you had any surgery, serious illnesses or accidents? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have allergies (Environmental or food allergies)? \_\_\_\_\_ Yes \_\_\_\_\_ No

*Still Tranquility, LLC*  
*10530 Campus Way South, #1135 Largo, MD 20774*  
*240-816-4358*

Do you have asthma or any other respiratory problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any medical conditions? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered yes to any of the above questions, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you take any medications regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list (dosage, frequency): \_\_\_\_\_

\_\_\_\_\_

Have you ever been examined by:

Ear, Nose, and Throat Doctor? \_\_\_\_\_ Yes \_\_\_\_\_ No

Neurologist? \_\_\_\_\_ Yes \_\_\_\_\_ No

Psychologist? \_\_\_\_\_ Yes \_\_\_\_\_ No

Other Medical Specialist \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain reason for visit and outcome: \_\_\_\_\_

\_\_\_\_\_

Please give place and dates of any previous evaluations or therapy:

Hearing: \_\_\_\_\_

Vision: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Occupational Therapy: \_\_\_\_\_

Psychotherapy: \_\_\_\_\_

Other: \_\_\_\_\_

Briefly describe any behavioral problems that you are facing at home/work \_\_\_\_\_

\_\_\_\_\_

Are there any past or present circumstances which you think could be related to your present difficulties? \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Do any family members have (or have had) a psychological disorder? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, who and what kind? \_\_\_\_\_

Please put any other comments that will help us understand you better \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Still Tranquility, LLC for myself and/or my family members.

*Still Tranquility, LLC*  
*10530 Campus Way South, #1135 Largo, MD 20774*  
*240-816-4358*

Patient Signature \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_