Information Packet

Name: _____ **Date:** _____
Home Phone #: _____ **Age:** _____
Cell Phone #: _____ **DOB:** _____
Address: _____ **Gender: M F**
City: _____ **Referred by** _____
Zip code: _____

If this is not the address you want correspondences sent to, indicate here _____

Your email address _____

Your employer: _____ Are you the insurance holder? _____

Occupation: _____ Hours: _____ Wk Phone #: _____

Marital Status: Single Divorced Married Common Law Marriage
Married: Currently married to: _____

Children and Ages: _____

Past psychiatric counseling or hospitalizations?
With whom and when?

_____

_____

Previous diagnosis: _____
Did therapy help you? _____
Have you ever filed a complaint against a therapist? If so, explain

_____

PRESENTING CONCERNS: _____

_____

_____

_____

Emergency Contacts

Emergency contact (other than self)_____
Telephone number: _____ Relationship: _____
Do you provide consent for your therapist to release your child to or contact this person in a situation perceived to be an emergency? _____No _____Yes

Family and Home Information

List all persons currently living in the primary household:

Name	Age/ Relationship	Sex	Education level	Degree

Natural parents or siblings who do not live in the household:

Name	Age/ Relationship	Sex	Education level	Degree

Family Medical History

Is there a **confirmed or suspected** history of any of the following in the family?

M= Mother / F=Father / GF=Child's Grandfather / GM= Child's Grandmother/ A= Child's Aunt / U= Child's Uncle

_____	Drugs	_____	Convulsions/seizures
_____	Alcohol	_____	Goiter (Thyroid)
_____	Depression	_____	Vision problems
_____	Anxiety	_____	Hearing Problems
_____	Bipolar	_____	Schizophrenia
_____	Mental retardation	_____	Suicide attempt

Is there a history of other conditions, not listed above? (Please explain) _____
_____
_____
_____

Domestic Violence

Is your house troubled by domestic violence? ___No ___ Yes

Have you been a victim of domestic violence? ___No ___ Yes

Do you have a history of sexual or physical abuse? ___No ___Yes

If "yes," please explain: _____

_____

Drugs/Alcohol

If any family member has a past or present alcohol or drug problem, please explain the extent:

_____

_____

Medical Conditions:_____

Current medications: _____

Detail all hospitalizations and surgeries:

_____

_____

Please indicate if there is anything significant that the therapist should be aware of that was not already asked in this questionnaire:

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete these questions. This information helps to provide the best care and treatment plan for you and your family.