Background Information

Name_____ Date: _____

Chief concern: Please describe the main difficulty that has brought you to see me:

_____

_____

_____

_____

_____

_____

Prior Treatment

1. Have you ever received psychological or counseling services before? □No □ Yes If yes:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever taken medications for psychiatric or emotional problems? □ No □ Yes If yes, please list medications taken and briefly describe the results:

_____

_____

_____

___

Abuse history: If you've ever been physically, emotionally, or sexually abused, please describe briefly:

_____

_____

_____

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_____

_

Present relationships

1. How do you get along with your present spouse or partner?

_____

_____

__

2. How do you get along with your children and/or your parents?

_____

_____

__

Chemical use

1. How much beer, wine, or liquor do you consume in an average week? _____

2. How much tobacco do you smoke or chew each week? _____

3. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

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_____

_

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, and their effects:

_____

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_____

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_____

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Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on this form? If yes, please tell me about it here:

_____

_____

_____

_____

_____