FOUNDATION therapies

www.foundationtherapies.com
651-472-6535

Client History

Welcome!
Please fill out the following form as completely as possible and bring to your first appointment. If you are attending therapy with a partner, each person should fill out his or her own forms.

Today's Date: _____

Client Information

Full Name: _____

Address: _____

City: _____ State: _____

Zip: _____ Gender: _____

Date of birth: _____ Age: _____

Preferred phone:_____
(Please provide the most convenient way to reach you about your appointment)

May I leave a message at this number? ☐Yes ☐No

Email:_____

May I email you? (I understand that email is not confidential) ☐ Yes ☐ No

What is your sexual orientation: _____

Do you identify as transgender? ☐ yes ☐ no
What are your preferred pronouns? _____

Relationship Status:
☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Relationship Style: ☐ Monogamous ☐ Non-Monogamous ☐ Polyamorous ☐ Other

Where did you hear about my services? _____
If online, ☐ Psychology Today ☐ Facebook ☐ My Website ☐Other (specify)

FOUNDATION therapies

Client History, Concerns and Goals

Describe current concerns and symptoms: _____

_____

_____

What are your goals for therapy? _____

_____

_____

Have you had previous counseling or treatment? ☐ Yes ☐ No
If yes, explain: (when, how long, location/therapist, reason): _____

_____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Are you currently feeling suicidal? _____

How would you rate your current physical health?

□ Poor □ Okay □ Good □ Great

How would you rate your sleep habits?

□ Poor □ Okay □ Good □ Great

How would you rate your eating habits?

□ Poor □ Okay □ Good □ Great

How many times per week do you exercise? _____

What type of exercise? _____

FOUNDATION therapies

www.foundationtherapies.com
651-472-6535

Please check areas of concern:

- ☐ Aggression
- ☐ Feeling depressed
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Difficulty sleeping
- ☐ Worry
- ☐ Disorganized
- ☐ Sleeping too much
- ☐ Panic attacks
- ☐ Trauma/abuse history
- ☐ Drug dependence
- ☐ Thoughts of suicide
- ☐ Avoiding people
- ☐ Avoiding issues
- ☐ Easily distracted
- ☐ Anxiety/nervousness
- ☐ Unmotivated
- ☐ Family problems
- ☐ Self-harm
- ☐ Excessive crying
- ☐ Gambling
- ☐ Racing heart
- ☐ Problems with friends
- ☐ Weight changes
- ☐ Perfectionism
- ☐ Hallucinations
- ☐ Intense fears
- ☐ Loneliness
- ☐ Hopelessness
- ☐ Appetite changes
- ☐ Stomachaches
- ☐ Difficulty breathing
- ☐ Lying
- ☐ Impulsiveness
- ☐ Irritability
- ☐ Feeling unimportant
- ☐ Argumentative
- ☐ Wishing to be dead
- ☐ Repetitive actions
- ☐ Nightmares
- ☐ Threatening or fighting
- ☐ Restlessness
- ☐ Sexual issues
- ☐ Difficulty concentrating
- ☐ Guilt
- ☐ Chest pain
- ☐ Obsessions
- ☐ Memory issues
- ☐ Partner difficulties
- ☐ Body image concerns
- ☐ Difficulty at work
- ☐ Chronic pain
- ☐ Bowel problems
- ☐ Headaches
- ☐ Menstrual problems
- ☐ STD/STI
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Dizziness
- ☐ Fatigue
- ☐ High blood pressure
- ☐ Abortion
- ☐ Miscarriage

Family History

List parents, siblings, and other significant people in your household while growing up:

Name: Relationship to you: Age: Still Living?

_____

_____

_____

_____

_____

_____

□ Parents legally married □ Parents divorced Mother remarried: Number of times: _____

Father remarried: Number of times: _____

FOUNDATION therapies

What was it like for you growing up in your family? _____

_____

_____

Are there any special or traumatic circumstances that affected your development (including verbal, physical or sexual abuse)? □ Yes □ No

If yes, please explain: _____

_____

Were you a victim or perpetrator of sexual abuse? _____

How were your parents as marital/sexual role models? What were their attitudes about sex?

_____

_____

Has anyone in your family had counseling, had suicidal thoughts/attempts, or involvement in self-help groups? □ yes □ no

If yes, please explain: _____

_____

List current partner(s), children, and other significant people in your household/life:

Name: Relationship to you: Age:

_____

_____

_____

_____

_____

Length of your current relationship(s): _____

Quality of current relationship(s): _____

Do you have sexual or intimacy concerns currently? □ Yes □ No

Describe your support system (family, friends, community involvement, etc.)

_____

_____

_____

Describe any spiritual or religious activities in which you are involved: _____

_____

Medical History

Date of your last physical exam: _____

Primary Care Physician: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Psychiatrist: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Describe your current health including diet, chronic health problems, etc.: _____

_____

Do you have any diagnosed medical or physical health issues? ☐ Yes ☐ No

If yes, please explain: _____

Please list major injuries, illnesses, or surgeries: _____

_____

Are you on any medications? ☐ Yes ☐ No

If yes, please list below:

Medication: Dose: Purpose: Date of Rx:

_____

_____

_____

_____

Have there been any recent changes in the following?

☐Sleep patterns ☐Eating patterns ☐Physical activity level ☐General disposition
☐Behavior ☐Energy level ☐Weight ☐Nervousness/tension

Describe changes in areas checked above: _____

_____

_____

Chemical Use History

	How often	**Date of first use**	**Date of most recent use**
Alcohol			
Marijuana			
Cocaine/Crack			
Heroin/Opiates			
PSP/LSD/Psychedelics			
Tobacco (e.g. cigarettes)			
Other			
Other			

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use):

_____

How do you believe your use affects your life? _____

Have you had a DWI/DUI? ☐ Yes ☐ No If yes, how many? _____

Education and Employment

Highest level of education/Degree: _____

Current employment and work history (brief summary): _____

_____

_____

_____

Have you served in the military? If yes, which branch? _____

When did you serve and for how long? _____

Legal

Are you involved in any legal proceedings? ☐Yes ☐No (Worker's comp, custody dispute, DUI, etc.)

If yes, please describe: _____

_____