

FAMILY INFORMATION

Father: _____
Name Age Deceased? Age at Time Date

Mother: _____
Name Age Deceased? Age at Time Date

BROTHERS AND SISTERS:			
Name	Age	Sex	Deceased? (date)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL INFORMATION

If Married Or In A Significant Relationship, How Many Years? _____

Spouse Or Partner's Name _____

Previous Marriages Or Significant Relationships:

Dates: from: _____ to: _____

Dates: from: _____ to: _____

Dates: from: _____ to: _____

Dates: from: _____ to: _____

Military Service?: _____ Dates: _____

Did You Serve In Combat? _____ Yes _____ No

NAMES AND AGES OF CHILDREN IN ORDER OF BIRTH				
Name	Age	Sex	Married?	Children?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have Any Children Died? _____ Yes _____ No

If yes, please give details: _____

BACKGROUND INFORMATION

(Check one for each question. Skip any question that does not apply.)

Did Your Parents Ever Have Problems With Alcohol Or Drug Use?

Yes ___ No ___

Did You Ever Have Problems With Alcohol Or Drug Use?

Yes ___ No ___

Has your partner (or other family member) ever hit, pushed, shoved, punched, kicked you or physically hurt you? Yes ___ No ___

Has anyone else ever physically hurt you? Yes ___ No ___

Have you ever been forced or pressured to participate in sexual activities when you did not want to by a partner (or other family member)? Yes ___ No ___

Has anyone else ever made you participate in sexual acts when you did not want to? Yes ___ No ___

Are you currently afraid (or have you ever been) in a relationship where you are threatened or made to feel afraid? Yes ___ No ___

Are you currently (or have you ever been) in a relationship with a partner or other person who frequently belittles you, insults you, blames you, puts you down or tries to control your behavior too much? Yes ___ No ___

SPIRITUAL HISTORY

Which religious tradition, if any, are you currently affiliated? _____None_____

Were you ever a part of a religious tradition? Yes ___ No ___

Was religion important in your family of origin? Yes ___ No ___

Do you draw on spiritual/religious beliefs to cope with life situations? Yes ___ No ___

Are there any spiritual/religious issues you would like to discuss in therapy? Yes ___ No ___

MEDICAL INFORMATION

Have You Had Previous Therapy? _____ When? _____

With Whom? _____

Are You Presently Seeing A Psychiatrist Or Another Therapist? _____

If So, Whom Are You Seeing? _____

Primary Care Doctor: _____

Are You Presently On Medication? _____

If So, Which Medication? _____

For What Condition? _____

Prescribed By? _____

CURRENT CONCERNS:

What Do You Consider Your Most Significant Difficulty Or Problem?

