Patient History Form

Please fll out this form to the best of your ability.

Please describe the main difculty that has brought you in for services.

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

○ yes ○ no

If yes, please indicate where and when you received treatment.

Have you ever taken medications for psychiatric or emotional problems?

○ yes ○ no

If yes, please indicate which medications you have taken or are currently taking.

Have you ever had psychological testing?

○ yes ○ no

If yes, please describe what diagnoses you were given and the recommendations you received.

Sleep Problems (check all that apply)

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep or waking up frequently
- ☐ Nightmares
- ☐ None.

Depression (check all that apply)

- ☐ Depressed mood
- ☐ Loss of pleasure in doing things you used to like
- ☐ Guilt
- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Withdrawal
- ☐ Moving more slowly than usual
- ☐ Agitation
- ☐ Difculty concentrating
- ☐ None.

Self-Harm (check all that apply)

- ☐ History of self-harm or suicide attempts
- ☐ Thoughts of harming or killing yourself
- ☐ Desire to harm or kill yourself
- ☐ Plans of harming or killing yourself
- ☐ None.

If yes, please describe.

Conduct Problems (check all that apply)

- ☐ Difculty following rules
- ☐ Lying
- ☐ Risk-taking
- ☐ Aggression
- ☐ Stealing
- ☐ Elopement/Breaking curfew
- ☐ Cruelty to animals
- ☐ Fire-setting
- ☐ Involvement with legal system
- ☐ Skipping school or work
- ☐ None.

If yes, please describe.

Harming Others (check all that apply)

- ☐ History of harming others
- ☐ Thoughts of harming others
- ☐ Desire to harm others
- ☐ Plans to harm others
- ☐ History of sexual aggression toward others
- ☐ None.

If yes, please describe.

Attention Problems (check all that apply)

- ☐ Hyperactivity
- ☐ Difculty Concentrating
- ☐ Difculty staying on task
- ☐ Forgetfulness
- ☐ Difculties with time management
- ☐ Difculties making deadlines
- ☐ Making careless mistakes
- ☐ Other
- ☐ None.

If yes, please describe.

Other Problems (check all that apply)

- ☐ Mania or history of bipolar symptoms
- ☐ Seeing/hearing/feeling things that aren't there
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Fear of crowds
- ☐ Social anxiety
- ☐ Headaches
- ☐ Nausea
- ☐ Body aches
- ☐ Vomiting
- ☐ Binging episodes
- ☐ Purging episodes
- ☐ Body image issues
- ☐ Other
- ☐ None.

If yes, please describe.

Trauma History (check all that apply)

- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Intimate partner violence
- ☐ Sexual assault
- ☐ Physical Assault
- ☐ Loss of or separation from a loved one
- ☐ Substance abuse
- ☐ Injury or accident
- ☐ Natural disaster
- ☐ Refugee or immigrant
- ☐ Incarceration
- ☐ Combat history
- ☐ Moral injury
- ☐ PTSD diagnosis
- ☐ Other
- ☐ None.

If yes, please briefy describe.

Trauma Symptoms - General (check all that apply)

- ☐ Intrusive memories

- [ ] Nightmares
- [ ] Zoning out or dissociating
- [ ] Flashbacks
- [ ] Becoming emotionally upset after triggers
- [ ] Becoming physically upset or reactive
- [ ] None.

Trauma Symptoms - Avoidance (check all that apply)

- [ ] Avoiding thoughts
- [ ] Avoiding feelings
- [ ] Avoiding memories
- [ ] Avoiding people
- [ ] Avoiding places
- [ ] Avoiding activities or duties
- [ ] None.

Trauma Symptoms - Emotional (check all that apply)

- [ ] Unable to remember important parts of the trauma
- [ ] Negative beliefs/expectations about self
- [ ] Negative beliefs/expectations about others
- [ ] Negative beliefs/expectations about the world
- [ ] Blaming yourself for what happened
- [ ] Persistent thoughts about the cause or consequence of trauma event(s)
- [ ] Persistent sadness/negativity/anger/agitation
- [ ] Less interest in activities that are important to you
- [ ] Detachment from others
- [ ] Detachment from responsibilities or duties
- [ ] Unable to feel happy or experience positive emotions
- [ ] Self-sabotaging behaviors
- [ ] None.

Trauma Symptoms - Reactivity (check all that apply)

- [ ] Reckless or destructive/self-destructive behaviors
- [ ] Startle response when there is a loud noise or someone surprises you
- [ ] Problems with concentration
- [ ] Problems with sleep

- [ ] Hypervigilance or feeling as if you're looking over your shoulder/feeling as if someone is following you
- [ ] Fear of being alone or going out alone
- [ ] None.

Please describe any other signifcant life stressors, such as a divorce, separation, interpersonal conficts, job loss, moving, fnancial problems, etc.)

Please describe your racial/ethnic identity.

Please describe your spiritual beliefs/practices and/or religious afliations.

Vocational/Employment History

Signifcant Family History - Medical, Psychological, Substance Use, Quality of Relationships

Please describe any social supports and current relationships you have.

Do you have any legal requirements by the court, police, or a probation/parole ofcer to attend psychotherapy?

○ yes ○ no

If yes, please explain.

Do you have any other legal involvement or custody arrangements?

○ yes ○ no

If yes, please explain.

Medical History (check all that apply)

☐ Hospitalizations

☐ Surgeries

☐ Head injury or traumatic injuries

☐ Chronic medical condition(s)

☐ Allergies/sensitivities

☐ Other accidents/injuries

☐ None.

If yes, please describe and when you experienced any of these.

Do you use tobacco products?

○ yes ○ no

If yes, how much and what products?

Please describe your alcohol intake in a given week or month.

Please describe any drug use or drug problems, including marijuana and prescription drug abuse.

Please describe your typical cafeine intake in a given week.

Please list all medications, drugs, or other vitamins, supplements, substances you have taken in the last year for medical reasons.

Current Medical Provider and Contact Information

Please describe your goals for treatment.