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CONFIDENTIAL

PATIENT INFORMATION FORM

Name: _____ **Age:** _____

Place of Employment: _____ **Work Phone:** _____

Employment Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____ **Years at Current Job:** _____

How did you find PFPA and/or your therapist? ☐ Friend ☐ Physician ☐ Relative ☐ Co-worker ☐ Internet ☐ Other: _____

Please describe the main difficulty that has brought you in to see a therapist: _____

Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the end of this form. You may also add any details or notes in the space next to the concerns checked.

- ☐ I have no problems/concerns
- ☐ Abuse (past or present)
- ☐ Alcohol/Drug Use
- ☐ Anger
- ☐ Anxiety
- ☐ Attention (ADHD/ADD Concerns)
- ☐ Depression
- ☐ Divorce, separation
- ☐ Eating Problems
- ☐ Fears, Phobias
- ☐ Financial Distress
- ☐ Friendship Difficulties
- ☐ Grieving, losses, mourning
- ☐ Health Concerns
- ☐ Interpersonal Conflicts
- ☐ Legal Matters
- ☐ Marital/Partner Conflict
- ☐ Mood Swings
- ☐ Obsessions &/or Compulsions
- ☐ Panic or Anxiety Attacks
- ☐ Self-Esteem
- ☐ Sexual Issues
- ☐ Stress Management
- ☐ Suicidal/Homicidal Thoughts
- ☐ Weight and/or Diet Issues
- ☐ Work-Related Concerns
- ☐ _____

What are your Top Three (3) Goals for therapy?

1) _____

2) _____

3) _____

Family and Relationship History

Please list everyone living in your home at this time, as well as any children living outside the home:

Name	Age	Relationship	Education (or Grade Level)	Occupation (or Name of School)

Children Outside the Home:

Name	Age	Relationship	Education (or Grade Level)	Occupation (or Name of School)

Relationship Status: ☐ Single ☐ Married ☐ In a Significant Relationship ☐ Divorced ☐ Widowed ☐ Other:

If applicable, please describe your spouse or significant other:

Name: _____ Age: _____

Education: _____ Occupation: _____

How long have you been together? _____

Have you or your significant other been previously married? ☐ Yes ☐ No

If so, please describe the dates and lengths of the previous marriage(s): _____

Medical History

How would you describe your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been hospitalized? ☐ Yes ☐ No If Yes, please give reason and year: _____

Medical History (continued)

Please check all medical conditions that apply:

- ☐ Heart Problems
- ☐ Digestive Problems
- ☐ Cancer
- ☐ Stroke
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Headaches/Migraines
- ☐ Asthma
- ☐ Diabetes
- ☐ STD
- ☐ High Cholesterol
- ☐ Allergies (Severe, Moderate, Mild)
- ☐ Arthritis
- ☐ Chronic Pain
- ☐ IBS
- ☐ Fibromyalgia
- ☐ HIV/AIDS
- ☐ Infertility
- ☐ Hepatitis

List any other conditions: _____

Are you currently taking any medications?

This includes prescribed medications, over-the-counter medications, vitamins, herbs, and others.

YES ➲ *If you are currently taking medication, please complete the attached medication information form.*

NO

Please list all medical doctors below with whom you are working on a regular basis (e.g., primary care physician, OB/GYN, etc.).

Name of Doctor	**Type of Doctor** (e.g., GP, OB/GYN, etc.)	Address/Location	Phone number

Substance Use History

Think about any and all chemicals you have used (currently or past) and indicate how much you used (amount) and how often. Then, indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	Age Started	Last Use	Amount?	How Often?	Effects/Consequences?
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Cocaine/crack					
Prescribed Pills					
Others: (Specify)					

Do you find that you are able to stop drinking or using drugs after having a moderate amount? ☐ Yes ☐ No

After drinking/using drugs for a period of time, have you ever had any of the following experiences? (Check all that apply.)

- ☐ Hangover
- ☐ Nausea or vomiting
- ☐ The "shakes"
- ☐ Blackouts (can't remember)
- ☐ Feelings of fear and anxiety
- ☐ Convulsions or seizures
- ☐ "D.T.'s"
- ☐ Getting arrested
- ☐ Losing personal friends
- ☐ Losing job or jobs
- ☐ Divorce or separation
- ☐ Financial Problems
- ☐ Serious medical problems
- ☐ Depression

Substance Use History (continued)

Have you ever tried to quit drinking or using drugs? ☐ Yes ☐ No If **yes,** please describe how and what happened:

Do you have any immediate family members who have problems (current or past) with any of the substances listed in this section?
☐ Yes ☐ No

If **yes**, please describe:

Mental Health History and Status

Have you ever received psychological, psychiatric, drug/alcohol treatment, or counseling services before? ☐ Yes ☐ No
If **yes**, please indicate:

When?	Provider's Name	Reason for Treatment	With what results?

Why did you discontinue services?

Have you ever taken medications for psychiatric or emotional problems? ☐ Yes ☐ No If **yes**, please indicate:

When?	Provider's Name	Name of Medication?	For What?	With what Results?

Have you or any member of your family, ever been treated or hospitalized for emotional problems? ☐ Yes ☐ No

If **yes,** please describe who, give date(s) and reason(s) for hospitalization(s):

Have you ever been arrested? ☐ Yes ☐ No If **yes,** please describe date(s) and type(s) of offense(s):

Employment History

Current Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed

Please list all previous jobs/job titles and the years that you held these jobs:

Employer/Job Title	**Date Range:** (e.g., 1998-2004)

Academic History

Check all that apply: ☐ High School ☐ College (2 year) ☐ College (4 year) ☐ Graduate School

Dates		**University/College Name**	**Degree(s)**
From	**To**		

Religious and Racial/Ethnic Identification (Optional)

Religious denomination/affiliation: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Islamic ☐ Buddhist

☐ Other: _____

Involvement: ☐ None ☐ Some/irregular ☐ Active

How important are spiritual concerns in your life? _____

Ethnicity/National Origin: _____ **Race:** _____

Or other similar way you identify yourself and consider important: _____