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RIDGEFIELD, CT 06877

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GENERAL INFORMATION:

NAME _____DOB _____

ADDRESS

_____
_____
_____

PHONE NUMBERS (H) _____ (O) _____

CELL_____ EMAIL _____

INDICATE WHAT NUMBER/EMAIL ADDRESS YOU'D MOST PREFER TO RECEIVE MESSAGES:_____
_____
_____
_____

PRESENTING PROBLEM: BRIEFLY DESCRIBE THE REASON(S) THAT YOU HAVE SOUGHT PSYCHOTHERAPY /COUPLES COUNSELING AT THIS TIME:

_____
_____
_____
_____
_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU FEEL ARE RELEVANT TO YOU:

STOMACH DISORDER FEEL TENSE RELATIONSHIP PROBLEM YELLING AT CHILDREN

STRESSED IN PARENTING CONSIDERING DIVORCE DIFFICULTY MAKING FRIENDS FATIGUE

FINANCIAL PROBLEMS SUICIDAL IDEAS CONCERNS ABOUT SEX HISTORY OF PHYSICAL ABUSE

HISTORY OF SEXUAL ABUSE NO APPETITE TROUBLE FALLING ASLEEP WAKING UP EARLY

NIGHTMARES CONCERNS ABOUT ALCOHOL OR DRUG CONSUMPTION UNABLE TO ENJOY LIFE

TROUBLE CONCENTRATING CAN'T REMEMBER WELL LOSS OF INTEREST IN THINGS

FEELING SAD MOST OF THE TIME EVERYTHING IS AN EFFORT FEARFUL MUCH OF THE TIME

WORRYING MOST OF THE TIME PANIC ATTACKS EATING OBSESSIONS

DIFFICULTY CONTROLLING ANGER UNHAPPY WITH WORK LIFE SPIRITUAL CRISIS

CIRCLE ANY OF THE FOLLOWING WORDS THAT YOU WOULD USE TO DESCRIBE YOURSELF:

INTELLIGENT CONFIDENT WORTHWHILE AMBITIOUS SENSITIVE LOYAL WORTHLESS

TRUSTWORTHY FULL OF REGRETS A NOBODY USELESS EVIL CRAZY CONSIDERATE

A DEVIANT UNATTRACTIVE UNLOVABLE INADEQUATE CONFUSED UGLY STUPID

HONEST INCOMPETENT CONFLICTED CONCENTRATION DIFFICULTIES ATTRACTIVE

MEMORY PROBLEMS CAN'T MAKE DECISIONS SUICIDAL IDEAS DETERMINED

GOOD SENSE OF HUMOR HARD WORKING CYNICAL OPTIMISTIC SPIRITUAL

MEDICATION HISTORY:

NAME OF MEDICINE	DATES USED	DOSE	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE ANY OF THESE MEDICINES BEEN HELPFUL TO YOU? IN WHAT WAYS?

_____
_____
_____
_____

NAME AND PHONE NUMBER OF PRESCRIBER

_____
_____

HAVE YOU EVER RECEIVED PSYCHOTHERAPY OR PSYCHIATRIC SERVICES BEFORE?

PROVIDER	DATES	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANY CURRENT MEDICAL PROBLEMS:

_____
_____
_____

NAME AND PHONE NUMBER OF YOUR PHYSICIAN:

_____
_____

ANY PAST MEDICAL PROBLEMS THAT ARE RELEVANT TO YOUR CURRENT SITUATION:

_____
_____
_____
_____

PROVIDE A BRIEF DESCRIPTION OF YOUR RELATIONSHIP WITH YOUR FAMILY MEMBERS:

SPOUSE: _____
_____
_____
_____

CHILDREN:
_____
_____
_____
_____
_____

PARENTS:
_____
_____
_____
_____

SIBLINGS:

_____
_____
_____
_____

DESCRIBE ANY CURRENT LEGAL INVOLVEMENTS (DUI ARRESTS, ETC.)

_____
_____
_____

DETAIL YOUR USE OF SUBSTANCES:

	AGE OF ONSET	AMOUNT	FREQUENCY	LAST USE
ALCOHOL	_____	_____	_____	_____
MARIJUANA	_____	_____	_____	_____
COCAINE/CRACK	_____	_____	_____	_____
SPEED/AMPHETAMINES	_____	_____	_____	_____
HEROIN	_____	_____	_____	_____
HALLUCINOGENS	_____	_____	_____	_____
PRESCRIPTION PILLS	_____	_____	_____	_____

HAVE YOU EXPERIENCED BLACKOUTS OR SEIZURES RELATED TO ALCOHOL/DRUG USE? IF YES, PLEASE EXPLAIN:

_____
_____

HAVE YOU EVER SOUGHT HELP FROM ALANON, AA, CODA, NA, OR OTHER SELF-HELP GROUPS?

_____
_____
_____
_____

WHAT ARE YOU HOPING TO GAIN FROM YOUR PSYCHOTHERAPY?

_____
_____
_____
_____
_____
_____