PACIFIC PSYCHOTHERAPY ASSOCIATES

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Date: ____________________ **Female**: ☐ **Male**: ☐

Name: **Last,** **First,** **Middle**

____

Home Address:____

City, State, Zip:____

Home/Cell Phone: _________________________ ☐ Message OK ☐ No message ☐ No calls

Work Phone: _______________________________☐ Message OK ☐ No message ☐ No calls

Email Address: ____

Age:____________ **Birth Date:** _______________ **Birth Place:** ______________________________

Relationship Status: Single Separated Divorced Married Partners Widowed

If Married / Partnered: how long?____________________
If Divorced, how long? _________________ If Widowed, how long?_______________

Please list names and ages of your children, if any:

____

Names & ages of all persons living in your home, and your relationship to them:

_____________________ ____________________ ____________________ __________________

Name of emergency contact <u>and</u> phone number:

____

How is this person related to you: ____

Please describe, the problem(s)/symptom(s) that bring you into counseling today:

Have you ever had a problem like this before (circle one)? **YES** **NO**
If YES, when did it happen and how did you deal with it?

Check the following that you may be experiencing:

☐	Dissatisfied with Life	☐	Sad or Depressed Feelings
☐	Can't Make Decisions	☐	Angry Feelings
☐	Feeling Stuck	☐	Recurring Thoughts
☐	Worried / Nervous	☐	Feeling Disconnected
☐	Lack of Motivation	☐	Thinking About the Past
☐	Unable to Focus	☐	Recent Death or Loss
☐	Feelings of Inferiority	☐	Caring for Sick or Elderly
☐	Appetite Problems	☐	Loneliness
☐	Sense of Failure	☐	Sexual Problems
☐	Forgetfulness	☐	Addictive Behaviors
☐	Sleep Problems	☐	Secret Behaviors
☐	Cheating / Infidelity	☐	Not Feeling Understood
☐	History of Being Abandoned	☐	Don't Like to be Alone
☐	Over-Ambitious / Workaholic	☐	Difficulty Controlling Temper

Have you experienced physical, sexual or emotional abuse (circle one)? **YES** **NO**
If YES, when?

Have you ever had a physical fight with your spouse or partner - such as throwing things, shoving, or hitting (circle one)? **YES** **NO**
If YES, please explain specifically:

Have you ever physically harmed anyone (circle one)? **YES** **NO**
If YES, please describe:

Have you ever been arrested for a crime (circle one)? **YES** **NO**
If YES, please explain:

In the past, have your ever contemplated or attempted suicide (circle one)? **YES** **NO**
If YES, please give dates and circumstances:

Has anyone in your family ever attempted suicide (circle one)? **YES** **NO**
If YES, please identify family member.

Has anyone in your family been diagnosed with a psychological or emotional problem (circle one)? **YES** **NO**
If YES, please specify:

Has anyone in your immediate family had a substance use or abuse problem (circle one)? **YES** **NO**
If YES, who, what problem, when?

Have you ever been in psychotherapy or counseling (circle one)? **YES** **NO**
If YES, give dates & type:

Are you currently employed? **YES** **NO**
If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

MEDICAL INFORMATION – CHECK ALL THAT APPLY

☐ ADD
☐ ADHD
☐ Anorexia
☐ Anxiety
☐ Back Problems
☐ BiPolar Disorder
☐ Bulimia
☐ Cancer (Please Specify Type and if in remission or undergoing treatment)
☐ Chronic Pain
☐ Colitis
☐ Concussion or Brain Trauma
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Fibromyalgia
☐ Heart Disease
☐ Hearing Problems
☐ HIV/AIDS
☐ Kidney Problems (if yes, are you on dialysis?) Liver problems or pancreatitis?
☐ Lupus
☐ Medical Treatment for Addiction (e.g., Methadone, Vivitrol)
☐ Multiple Sclerosis
☐ Neurological Disorders
☐ Other Sexually Transmitted Diseases (please specify)
☐ Schizophrenia
☐ Others not listed

____

☐ List all prescription medication:

____

Substance Use:

☐ Alcohol – Amount & Frequency: ____
☐ Cigarettes – Amount & Frequency: ____
☐ Marijuana – Amount & Frequency:____
☐ Methamphetamines – Amount & Frequency:__________________________________
☐ Cocaine – Amount & Frequency:____
☐ Ecstasy – Amount & Frequency:____
☐ Opiate / Heroin – Amount & Frequency:_____________________________________