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

I agree and give my consent for services by Pacific Psychotherapy Associates:

Signature_____***Date:***_____