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**Licensed Marriage and Family Therapist**

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**PSYCHOLOGICAL & SOCIAL BACKGROUND SUMMARY**

*Please provide the following information for our records. Leave blank any question you would rather not answer at present. Information you provide here is held to the same standards of confidentiality as our therapy.*

*Please bring this form to your first session and allow yourself 30 minutes prior to your appointment to complete the form in the office. Thank you.*

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Marital Status: (please circle one)

Never Married Married Separated Divorced Widowed

Local Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) - May we leave a message? YES / NO

Work Phone: ( ) - May we leave a message? YES / NO

Cell/Other Phone: ( ) - May we leave a message? YES / NO

E-mail: \_\_\_\_\_ May we email you? YES / NO  
(Please be aware that email might not be confidential.)

Biological Mother: \_\_\_\_\_

Biological Father: \_\_\_\_\_

Siblings and Ages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently in a couple relationship (marriage, dating, etc.)? YES / NO

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, low to high, rate the quality of your current relationship: \_\_\_\_\_

If applicable, list name(s) and age(s) of:

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OCCUPATIONAL INFORMATION:**

Are you currently employed? YES / NO

If yes, who is your current employer?

\_\_\_\_\_

Describe what type of work you do:

\_\_\_\_\_

How many hours per day and per week do you work?

\_\_\_\_\_

On a scale of 1 to 10, with 1 being very unhappy to and 10 very happy, how would you rate how much you enjoy and are happy with your work? \_\_\_\_\_

Please list any work-related stressors, if any:

\_\_\_\_\_

**PRESENTING ISSUE**

What is the problem for which you seek counseling?

\_\_\_\_\_

\_\_\_\_\_

What have you done about this problem that has worked? How has it worked?

\_\_\_\_\_

\_\_\_\_\_

What have you done that has not worked? How do you know?

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What emotions do you feel when you think about this problem?

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On a scale of 1 to 10, low to high, how intense are these emotions when you think about the problem? \_\_\_\_\_

What other persons, if any, are affected by this problem?

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### **STRESS ISSUES**

In the last year, have you experienced any significant life changes? If yes, please describe:

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What level of stress do you feel you are experiencing at this time? (Check one.)

Minimal       Average       Considerable       Unbearable

What are the major factors of your stress? (Check all that apply.)

Financial       Marital       Health       Unfulfilled expectations

Spiritual       Career       Family       Children

Body image       Other \_\_\_\_\_

How does your stress manifest itself (use back, if need more space)?

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How do you cope with stress?

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How would you **prefer** to cope with stress?

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**PHYSICAL CARE AND LIFESTYLE**

How do you rate your physical health at present? (please circle one)

Poor      Unsatisfactory      Satisfactory      Good      Very good      Excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

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Are you having any problems with your sleep habits?    YES / NO

If yes, circle all that apply:

Sleeping too little      Sleeping too much      Poor quality sleep  
Disturbing dreams      Other \_\_\_\_\_

How many hours, on average, do you sleep at night? \_\_\_\_\_

Do you nap during the day, and if so, how many hours? \_\_\_\_\_

What time do you go to sleep at night? \_\_\_\_\_

Do you awaken feeling rested? \_\_\_\_\_

Describe any other regular sleep disturbances, if any, and state how often:

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Are you having any difficulty with appetite or eating habits?    YES / NO

If yes, circle all that apply:    Eating less    Eating more    Binging    Restricting

Have you experienced significant weight change in the last 2 months?    YES / NO

Describe weight changes, if any:

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Do you smoke? YES / NO

If yes, how many cigarettes per day? \_\_\_\_\_

If no, does anyone in your household smoke    YES / NO

If yes, how many family members smoke: \_\_\_\_\_

Do you drink alcohol? YES / NO

If yes, how many drinks on average per day in past year? \_\_\_\_\_

At most, how many drinks have you had in one night in the past year? \_\_\_\_\_

Do you use any recreational drugs? YES / NO

If yes, how often and what type? \_\_\_\_\_

How many main meals a day do you eat? \_\_\_\_\_ Times of day? \_\_\_\_\_

How many snacks a day do you eat? \_\_\_\_\_ Times of day? \_\_\_\_\_

In your opinion, do you regularly keep a healthy eating lifestyle? YES / NO

Describe the reasons you think it is or isn't healthy:

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Indicate how often you eat or use the following (1 – rarely; 2 – regularly; 3 – often)

- Luncheon meats    Candy    Margarine    Processed foods  
 Cigarettes    Microwave    Fried foods    Artificial sweeteners  
 Aluminum pans    Desserts    Cooking wine    Over the counter drugs

Indicate how many cups or glasses you drink per day of the following:

- Coffee    Tea    Herbal tea    Soft drink    Diet soft drink  
 Milk    Water    Wine    Beer    Other alcohol

How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

If applicable, what do you do for exercise?

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How many times per week do you **want** to exercise, and for how long?

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How many hours, on average, per day do you spend:

- Driving    Watching TV    Reading    In front of computer

What are your interests and hobbies, present and past?

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Do you vacation regularly? YES / NO

When was your last vacation, where did you go, and for how long?

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**RELIGIOUS/SPIRITUAL**

Do you actively participate in a religious or spiritual discipline? YES / NO

If no, do you consider yourself to be spiritual? YES / NO

If yes or no, please elaborate:

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Do you meditate, have a quiet time or pray regularly? YES / NO

**PREVIOUS OR OTHER TREATMENT**

Are you currently receiving professional counseling or therapy elsewhere? YES / NO

Are you currently receiving psychiatric services? YES / NO

If yes to either above, please list type of service, dates, problem, name and address of provider (if you need more space, use the back):

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Are you currently taking prescribed psychiatric medication (i.e., antidepressants)? YES / NO

If yes, please list medication and dosage:

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Have you received psychological services in the past? YES / NO

If yes, please list type of service, dates, problem, name and address of provider (if you need more space, use the back):

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List any past medications (no longer taking), dosage and the reason each was prescribed:

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Are you currently being treated for medical problems? In the past? YES / NO

If yes to either above, please list problem, dates, medication/dosage, name and address of provider (if you need more space, use the back):

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**DEVELOPMENTAL HISTORY**

Date and place of birth: \_\_\_\_\_

Describe pertinent information during pregnancy, birth, and early development:

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Describe any pertinent academic issues and educational experiences:

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**Have you experienced any of the following in the past or present (please circle):**

Extreme depressed mood	YES / NO	Past / Currently
Wild Mood Swings	YES / NO	Past / Currently
Rapid Speech	YES / NO	Past / Currently
Extreme Anxiety	YES / NO	Past / Currently
Panic Attacks	YES / NO	Past / Currently
Phobias	YES / NO	Past / Currently
Sleep Disturbances	YES / NO	Past / Currently
Hallucinations	YES / NO	Past / Currently
Alcohol/Substance Abuse	YES / NO	Past / Currently
Frequent Body Complaints	YES / NO	Past / Currently
Eating Disorder	YES / NO	Past / Currently
Body Image Problems	YES / NO	Past / Currently
Repetitive Thoughts (e.g., Obsessions)	YES / NO	Past / Currently
Repetitive Behaviors (e.g., Checking, Hand-Washing)	YES / NO	Past / Currently
Homicidal Thoughts	YES / NO	Past / Currently

Have you had suicidal thoughts in the last two months? (Please circle one)

Frequently      Sometimes      Rarely      Never

Have you had suicidal thoughts in the past? (Please circle one)

Frequently      Sometimes      Rarely      Never

Have you made at suicide attempts in the past?

If yes, list dates: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Date and place of birth: \_\_\_\_\_

Describe pertinent information during pregnancy, birth, and early development:

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Describe any pertinent academic issues and educational experiences:

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**FAMILY MENTAL HEALTH AND TREATMENT HISTORY:**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle yes or no to each, and list family member, e.g., Sibling, Parent, Uncle, etc.):

**Difficulty**

**Family Member(s) Affected:**

- |                         |          |
|-------------------------|----------|
| Depression              | YES / NO |
| Bipolar Disorder        | YES / NO |
| Anxiety Disorders       | YES / NO |
| Panic Attacks           | YES / NO |
| Schizophrenia           | YES / NO |
| Alcohol/Substance Abuse | YES / NO |
| Eating Disorders        | YES / NO |
| Learning Disabilities   | YES / NO |
| Trauma History          | YES / NO |
| Suicide Attempts        | YES / NO |

Describe family history of psychological treatment, if any:

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Describe family history of drug and/or alcohol dependency, if any:

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Describe other pertinent factors in family history, i.e., abuse, trauma:

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**COUPLE RELATIONSHIP**

Briefly describe relationship with spouse, or significant other, if applicable:

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Briefly describe your relationship with parents and siblings, if applicable:

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Briefly describe your relationship with your children, if applicable:

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Describe other information regarding your home life that may be relevant to restoring your mental, emotional, and physical health and wholeness:

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**PREVIOUS MARRIAGES**

Have you been previously married? YES / NO

If yes, provide the following information, for each:

<u>Years Married</u>	<u>Total Years Together</u>	<u>Years Divorced</u>	<u>Reason for Divorce</u>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

**OTHER INFORMATION**

What do you consider to be your strengths?

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What do you like most about yourself?

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What are effective you've learned to cope with challenges and stress?

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What are your goals for therapy?

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**FAMILY THERAPY**

List any family members over the age of 12 you may want to include in family therapy in the future:

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Have you considered, or are you willing to engage in couple therapy, if necessary (and applicable):

YES / NO / MAYBE

If YES, is your spouse or significant other, in your opinion, willing to engage in couple therapy, if necessary:

YES / NO / MAYBE