



**PERSONAL/FAMILY INFORMATION**

(Please Print Clearly)

**Family Information:** List all family and household members

Name	Relationship	Age	Occupation/Grade	Residing w/you
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No

**Marital/Relationship History:** List all marital or partner relationships including present:

Name of Spouse/Partner	Date Married	Terminated by	Date
		<input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation	
		<input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation	
		<input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation	
		<input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation	

**Education:** Circle Highest Grade Completed and Additional Training

0	1	2	3	4	5	6	7	8	9	10	11	12
College	1	2	3	4	Graduate School	Vocational	Business					

**Religious/Spirituality/Support:**  
If applicable please list any religious affiliation, spirituality practices or social support system or resources:




Family History:	Age if Living	Age at Death	Date of Death	Cause of Death			
Father							
Mother							
Sisters							
Sister #1							
Sister #2							
Sister #3							
Sister #4							
Brother #1							
Brother #2							
Brother #3							
Brother #4							
Family Medical History:	Yes	No	Relationship		Yes	No	Relationship
AIDS				Kidney Disease			
Alcohol/Drug Abuse				Liver disease			
Anemia/Blood Disorder				Mental Retardation			
Arthritis				Migraine Headaches			
Asthma/Emphysema				Neurological Problem			
Cancer				Obesity			
Diabetes				Physical Disability			
Epilepsy				Psychiatric Problem			
Glaucoma				Thyroid Disorder			
Heart Disease				Tuberculosis			
High Blood Pressure				Ulcer			
Allergies (list):							



Personal Medical History:	Yes	No	Date Diagnosed		Yes	No	Date Diagnosed
AIDS				Kidney Disease			
Alcohol/Drug Abuse				Liver disease			
Anemia/Blood Disorder				Mental Retardation			
Arthritis				Migraine Headaches			
Asthma/Emphysema				Neurological Problem			
Cancer				Obesity			
Diabetes				Physical Disability			
Epilepsy				Psychiatric Problem			
Glaucoma				Thyroid Disorder			
Heart Disease				Tuberculosis			
High Blood Pressure				Ulcer			
Substance Abuse				Eating Disorder			
Infertility							
<b>Anything not listed above:</b>							
<b>Allergies (list):</b>							
<b>Serious Injuries (list):</b>							
<b>Any operations?</b> <input type="radio"/> Yes <input type="radio"/> No If yes, please list:							
<b>Any psychiatric hospitalization?</b> <input type="radio"/> Yes <input type="radio"/> No When: _____ Where: _____							
<b>Any substance abuse problems?</b> <input type="radio"/> Yes <input type="radio"/> No If yes, list: _____							
<b>Number of pregnancies:</b>				<b>Number of miscarriages:</b>			
<b>Number of children:</b>				Living		Deceased	



**Do you have any present physical illness?**  Yes  No If yes, please list:

**Name and number of treating physician:**

**Are you currently taking any medication?**  Yes  No If yes, please list:

**Any previous psychotherapy?**  Yes  No If yes, please list:

When:

Where:

**How helpful was it?**  Not helpful  Somewhat Helpful  Very Helpful

**If helpful, what was helpful about it?**

**If not helpful, explain why?**

**Clinical Information:** Please check any of the following that apply to you:

- |  |   |   |
|--|---|---|
| <input type="radio"/> Headaches                    | <input type="radio"/> Tremors/Shaking               | <input type="radio"/> Shy with people       |
| <input type="radio"/> Dizziness                    | <input type="radio"/> Financial problems            | <input type="radio"/> Can't make friends    |
| <input type="radio"/> Fainting Spells              | <input type="radio"/> Parent/child problems         | <input type="radio"/> Can't make decisions  |
| <input type="radio"/> Palpitation (fast heartbeat) | <input type="radio"/> Court/legal problems          | <input type="radio"/> Can't keep a job      |
| <input type="radio"/> Stomach trouble              | <input type="radio"/> Disturbing thoughts or fears  | <input type="radio"/> No ambition           |
| <input type="radio"/> No appetite                  | <input type="radio"/> Fear of losing control        | <input type="radio"/> Inferiority feelings  |
| <input type="radio"/> Bowel disturbances           | <input type="radio"/> Depressed                     | <input type="radio"/> Marital problems      |
| <input type="radio"/> Unusual bodily sensations    | <input type="radio"/> Suicidal ideas                | <input type="radio"/> Drugs                 |
| <input type="radio"/> Tired, no interest or energy | <input type="radio"/> Always worried                | <input type="radio"/> Unusual mental exp.'s |
| <input type="radio"/> Poor sleep                   | <input type="radio"/> Unable to relax               | <input type="radio"/> Hear voices           |
| <input type="radio"/> Nightmares                   | <input type="radio"/> Unable to have a good time    | <input type="radio"/> Visual hallucinations |
| <input type="radio"/> Take sedatives               | <input type="radio"/> Don't like weekends/vacations | <input type="radio"/> Drinking problem      |
| <input type="radio"/> Overanxious                  | <input type="radio"/> Feel Tense                    | <input type="radio"/> Sexual problems       |
| <input type="radio"/> Lose things                  | <input type="radio"/> Spaciness/disorientation      | <input type="radio"/> Other: List below     |



**Availability for Treatment**

Would you be able to come to this office for an hour or more each week (if necessary) during the day?  Yes  No

What times are you unable to come during the day?

Do you have adequate transportation to come here as often as needed?  Yes  No

If no, can you arrange for the needed transportation?  Yes  No

Please indicate interest in the following (check all that apply):

- Individual Therapy
- Family Therapy
- Group Therapy
- Marital Therapy
- Hypnotherapy
- Infertility Counseling
- Donor and or Donor Recipient Assessment
- Other:

Patient Signature

Date

Any additional comments, concerns or questions about this process?