PERSONAL/FAMILY INFORMATION

(Please Print Clearly)

FAMILY INFORMATION: List all family and household members

Name	Relationship	Age	Occupation/Grade	Residing w/you
				❍ Yes ❍ No
				❍ Yes ❍ No
				❍ Yes ❍ No
				❍ Yes ❍ No
				❍ Yes ❍ No
				❍ Yes ❍ No
				❍ Yes ❍ No

MARITAL/RELATIONSHIP HISTORY: List all marital or partner relationships including present:

Name of Spouse/Partner	Date Married	Terminated by	Date
		❍ Divorce ❍ Death ❍ Separation	
		❍ Divorce ❍ Death ❍ Separation	
		❍ Divorce ❍ Death ❍ Separation	
		❍ Divorce ❍ Death ❍ 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:

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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				Mentally Challenged			
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				Mentally Challenged			
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							

Anything not listed above:

Allergies (list):

Serious Injuries (list):

Any operations? ❍ Yes ❍ No If yes, please list:

Any psychiatric hospitalization? ❍ Yes ❍ No When: Where:

Any substance abuse problems? ❍ Yes ❍ No If yes, list:

Number of pregnancies: **Number of miscarriages:**

Number of children: Living Deceased

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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:

❍ Headaches
❍ Dizziness
❍ Fainting spells
❍ Palpitation (fast heartbeat)
❍ Digestive issues
❍ Loss of appetite
❍ Bowel disturbances
❍ Unusual bodily sensations
❍ Tired, no interest or energy
❍ Insomnia
❍ Nightmares
❍ Take sedatives
❍ High anxiety
❍ Absent minded

❍ Tremors/Shaking
❍ Financial problems
❍ Parent/child problems
❍ Court/legal problems
❍ Disturbing thoughts or fears
❍ Fear of losing control
❍ Depressed
❍ Suicidal ideas
❍ Always worried
❍ Unable to relax
❍ Unable to have a good time
❍ Don't like weekends/vacations
❍ Feel Tense
❍ Light headed/disorientation

❍ Shy with people
❍ Introvert
❍ indecisive
❍ Can't keep a job
❍ Lack of ambition/goals
❍ Inferiority feelings
❍ Marital problems
❍ Drugs
❍ Unusual mental exp.'s
❍ Hear voices
❍ Visual hallucinations
❍ Drinking problem
❍ Sexual problems
❍ 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?