

Patricia Holden, M.A., M.F.T.

www.edlightenment.com

Your Name: _____ Date of Birth _____

Address: _____

City/State/Zip: _____

Phone: (Home) _____ (Work) _____

(Cell) _____ Other, please specify) _____

please indicate your preferred contact number by marking it with an √

Emergency Contact: (Name) _____

(Phone) _____ Relationship _____

Referred by: _____ Phone _____

For Non-Network Patients ONLY: REIMBURSEMENT: If you would like me to send you a monthly statement, which you can forward to your insurance company to request reimbursement, please indicate below:

Monthly Statement (circle one) Yes No

Address to send the monthly statement to: (circle one) Home Business Other

Age: _____ Gender: _____ Date of Birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Religious Background: Protestant Catholic Jewish Muslim Buddhist

(circle one)

No Affiliation Other _____

Marital Status: Single/Never Married Married Separated Divorced

(circle one)

Widowed Cohabiting

If divorced, when did you divorce your previous partner? _____

How long were you married? _____

Education: (number of years completed) _____

Occupation: _____

Are you working now? (circle one) Yes No If yes, circle one: Full-Time Part-time

Are you going to school now? (circle one) Yes No If yes, circle one: Full-Time Part-time

Names of persons living in your home & your relationship with them:

Name

Relationship

Spouse/Partner's Occupation (if applicable): _____

Please provide information about your family:

Mother Name: _____

If deceased, year & cause of death: _____

If living, age & health status: _____

If living, where does she live now? _____

Her occupation (past &/or present): _____

Father Name: _____

If deceased, year & cause of death: _____

If living, age & health status: _____

If living, where does he live now? _____

His occupation (past &/or present): _____

Siblings:

Name

Age

Occupation

Where does he/she live now?

Where did you grow up? _____

Were your parents ever separated? (circle one) Yes No If yes, when? _____

Did your parents get divorced? (circle one) Yes No If yes, when? _____

Did they remarry? (circle one) Yes No If yes, when? _____

At what age did you move out of your parent's house? _____

What is the highest degree you earned in school? _____ When? _____

Did you ever leave a school you were enrolled in prior to completion? (circle one) Yes No

If yes, give details: _____

Did you ever receive any special education services (e.g., academic tutoring, IEP, classroom accommodations, etc.)? (circle one) Yes No If yes, give details: _____

If you were physically disciplined as a child, were you ever injured as a result? (circle one) Yes No

Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? (circle one) Yes No

Have you experienced or witnessed any traumas (events that felt life-threatening)? (circle one) Yes No

Have you ever experienced physical or sexual abuse or assaults? (circle one) Yes No

Please provide some information about your work history:

Type of Job Held

How Long

_____	_____
_____	_____
_____	_____
_____	_____

If you have a partner or spouse, how long have you been together? _____

Please list names & ages of children, if applicable

Name	Age	Biological?	Name	Age	Biological?
_____		Y / N	_____		Y / N
_____		Y / N	_____		Y / N

Please describe, briefly, the problem(s) that bring you in to see me. What are the symptoms, how intense are they, and how often do they occur?

Have there been problems like this before? (circle one) Yes No

If yes, when? _____

Are you presently seeing another therapist? (circle one) Yes No

If yes, please give me the following information: (this is for background only, you are *not* consenting to me contacting):

Therapist's Name _____ Date Treatment Began _____

Therapist's Address _____

Therapist's Phone Number _____

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy? (circle one) Yes No

If yes, please give me the following information (this is for background only, you are *not* consenting to me contacting):

Therapist's name(s), phone number(s), & address(es):

Date(s) of Treatment: _____

Problem for which treatment was sought?: _____

If you had psychotherapy before, was it helpful? (circle one) Yes No

If yes, how was it helpful? _____

If no, in what way was it unsatisfactory? _____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended to you? (circle one) Yes No

If yes, when and why? _____

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? (circle one) Yes No If yes, when, for how long, and why?

Was the hospitalization voluntary? (circle one) Yes No

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties (e.g., Prozac, Xanax, etc.)? (Circle one) Yes No

If yes, what medications were recommended, when, and for what symptoms?

Medication	Symptoms	Medication	Symptoms
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever *taken* medications for mental or emotional difficulties prescribed by a physician/psychiatrist?
(circle one) Yes No

If yes, what medications were prescribed, when & for what symptoms?

Medication	Symptoms	Medication	Symptoms
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently using any prescribed medications? (circle one) Yes No

Please indicate what medications you are *currently* taking:

Medication	Dosage	When Started	Prescriber
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The following information will help me understand your needs and recommend appropriate treatment.

Have you ever used any drugs or medications other than as prescribed? This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, prescribed drugs (e.g. , valium), Ecstasy, and others.

(circle one) Yes No Are you currently using? (circle one) Yes No

If yes, please check and provide the requested information:

Type	Frequency/Amount	Duration	Amount
_____	_____	_____	_____
_____	_____	_____	_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school, or relationships? (circle one) Yes No

If yes, please explain: _____

Do you drink alcohol? (circle one) Yes No

How much alcohol do you drink? _____ Drinks per _____

Do you feel alcohol has caused any problems in your work, school, or relationships?

(circle one) Yes No If yes, please explain _____

Has treatment for drug or alcohol ever been recommended to you? (circle one) Yes No

If yes, please describe the circumstances and give dates. _____

Have you ever been treated for alcohol abuse? (circle one) Yes No

If yes, please describe the provider and program, give dates, and describe the outcome.

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? (circle one) Yes No

Do you currently have, or have you had in the past, any serious, chronic, or recurrent health problems or disabilities? (circle one) Yes No

If yes, please describe: _____

List dates of surgeries/hospitalizations you have had for physical problems:

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Do any of your biological relatives have a history of psychiatric, emotional, or substance abuse problems? (circle one) Yes No

If yes, which family members and what types of problems? _____

Have you ever been involved in a lawsuit? (circle one) Yes No

If yes, please describe circumstances and give dates.

Have you ever been arrested for a crime? (circle one) Yes No

If yes, please describe the circumstances and give dates. _____

Have you experienced any particular sources of stress in the last year? (circle one) Yes No

If yes, please explain:

Are there any other health care professionals (e.g., physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment? (circle one) Yes No

If yes, please give details: _____

Is there any other background information you think would be helpful for me to know?

(circle one) Yes No If yes, please explain _____

Signature

Date