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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: 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: (circle one) Protestant Catholic Jewish Muslim Buddhist

No Affiliation Other ____________________

Marital Status: (circle one) Single/Never Married Married Separated Divorced

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