

CONFIDENTIAL INITIAL INFORMATION FORM

Welcome to the practice of Susan Nelson, M.A., L.C.S.W., specializing in therapy for women. Providing you with the best possible care is of utmost importance. To assist in meeting your needs, please fill out this form completely in ink. If you are viewing this form on the website, you will need to print the form on your printer first and then complete. Please bring the completed form with you to your first session. Your information will be held in strictest confidence.

Name of Patient: _____ Date: _____
 Date of Birth: _____ Age: _____ Referred By: _____

What is the reason you are seeking treatment at this time?

What do you hope to accomplish from therapy?

FAMILY HISTORY

Marital status: ___single / ___married / ___divorced / ___separated / ___engaged / ___widowed

Name of spouse: _____

Spouse's birth date: ___/___/___ Date of marriage: ___/___/___ # of your other marriages: _____

Spouse's employer: _____ Spouse's work #: () _____

Children:

Name:	Age	Gender	Living at home?	Occupation	Marital Status	Health Status

Father

Name: _____

Is he/she living? _____

If deceased, what is the cause and date of death?

Cause: _____

Date: _____

Mother

Brothers and/or Sisters:

Name	Age	Gender	Occupation	Health Status	If deceased, what was cause?

What is your numerical order in the family? _____

Has there been any psychiatric illness within the family? (include diagnosis, if known): _____

Any that required hospitalization? _____

Any suicidal / homicidal behavior? _____

Any drug or alcohol problems? _____

Education: How many years of schooling have you had? _____ What degrees have you earned? _____

Current Living Situation: (Check all that apply)

___ Live alone ___ With spouse ___ With children ___ With parents ___ With others
 ___ With siblings ___ With other relative(s) ___ In an institution ___ Other situation (describe) _____

Religion: ___ Protestant / ___ Roman Catholic / ___ Jewish / ___ Other / ___ None /

___ Active / Inactive ___

GENERAL MEDICAL HISTORY

Name of primary care physician: _____ Office #: () _____

Last physical examination within one year? _____ Thyroid checked? _____ Results: _____

Current medical problems (and names of physicians treating you for each):

_____Current medications you are taking, (note what condition each is for):

Over-the-counter medicals, supplements, herbals: _____

Drug allergies: _____

Past medical problems: _____

List any previous surgeries (include abortions) or hospitalizations: _____

Do you regularly drink alcohol? _____ yes _____ no If yes, what form and how much? _____

Has your drinking ever been a problem to you or to others? _____

Do you have a history of using illegal/recreational drugs or abusing medications? _____ yes _____ no

If yes, what illegal drugs and what medications? _____

How many beverages containing caffeine do you drink per day? _____

Do you use tobacco? _____ How much? _____ Do you desire to quit? _____

Are you currently under a lot of pressure at home or school or work? _____ yes _____ no

Please check if you have had any of the following:

ulcers

colitis

self harm (cutting, etc.)

depression

bipolar disorder

suicide attempts

paranoid thinking

delusions

hallucinations

eating disorder

obsessive thoughts

obesity

irrational fears

severe anxiety

drug/alcohol problems

sexual abuse

physical abuse

difficulty hearing

memory loss

headaches, migraines

panic attacks

insomnia

convulsions/seizures

diabetes

cancer

increased energy ("highs")

racing thoughts

gambling problems

impulsive sexual behaviors

impulsive shopping

digestive problems

skin disorders

nightmares

Current/recent stresses: (Check all that apply)

___ Death of spouse/ other

___ Break-up of relationship

___ Child/ other left home

___ Health of family member

___ Behavior of family member

___ Retired, loss of job

___ Financial problems

___ Legal problems

___ Personal injury or illness

___ Change of residence

___ Serious argument

___ Other (describe)

Prior psychiatric history:

Approximate date of all inpatient and outpatient treatment, with diagnosis (include marital/family therapy):

Names of all prior prescribed psychiatric medications and for what conditions:

Names of all current psychiatric medications/ when began/ prescribing physician:

Time since last psychiatric or counseling service:

___ no prior service ___ within the same day ___ within 7 days ___ within 30 days ___ within 6 months

___ within one year ___ over one year

Were you treated inpatient _____ or outpatient? _____ (Check all that apply)

Have you formally terminated counseling with your previous therapist? _____ yes _____ no _____ n/a