PAST THERAPY / PSYCHIATRIC TREATMENT

Dates **Place** **Therapist Name**

_____ _____ _____

_____ _____ _____

Marital Status: _____Married _____Single _____Divorced _____Widowed
Number of marriages (including current one)_____
Length of each marriage (years) 1st_____ 2nd_____ 3rd_____ 4th_____ 5th_____
Number of children_____ (ages) _____; _____; _____; _____; _____; _____; _____

Names of Persons in Household	**Relation**	**Age**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last grade completed / Level of education _____
Current job_____ How Long? _____
Number of jobs held in the past five (5) years _____
Do you have any current of past legal proceedings? _____Yes _____No
If yes, please explain _____
_____
_____

Medical Information

Please list any significant illnesses, injuries, or surgeries and dates:_____
_____
Please list all medications currently taking (including over-the-counter medications): _____
_____
Do you use tobacco? _____Yes _____ No How much per day?_____
Do you use marijuana? _____ Yes _____ No How much per day?_____
Do you drink alcohol (beer, wine, liquor)? _____ Yes _____ No How much per day?_____
Is there anyone living in your household who uses drugs or alcohol to the extent that it would affect your counseling process?_____
Have you any blood relative suffered from:
Alcohol or drug problems _____ Self _____ Relative Which relative?_____
Depression _____ Self _____ Relative Which relative?_____
Anxiety or "nerve" problem _____ Self _____ Relative Which relative?_____
Attention Deficit Disorder _____ Self _____ Relative Which relative?_____

How did you hear about us? ___ Internet Search ___ Professional Referral ___ Personal Referral ___ Yellow Pages ___ Social Media ___Other? Please Explain_____

I hereby release any information acquired in the course of my treatment and assign any benefits to Counseling Professionals or Elisabeth H. Lynch, MA, LPC.

_____ _____
Patient Signature **Date**

_____ _____
Insured of Authorized Person's Signature (if different from patient) **Date**