

Today's Date _____

Texas Woman's University Counseling and Family Therapy Clinic (CFTC)

At this office we do not perform "forensic services" and cannot provide "forensic opinions, reports, assessments, and/or recommendations" according to Rule 465.18 of the Texas Administrative Code, Title 22.

Client's Name _____ Date of Birth _____ Age _____

Address _____ Gender (circle one) Male Female

City _____, TX ZIP _____

Marital Status: _____

Education- Highest grade or degree _____

Race or ethnicity (write in) _____

Occupation: _____

If you are completing this form for a minor child, we are required to ask if you are the legal guardian of the minor child.

Are you currently on probation? (Circle one)	YES	NO
Are you currently using recreational drugs? (Circle one)	YES	NO
Where you referred by MHMR or CPS? (Circle one)	YES	NO

The staff at the CFTC values your right to privacy concerning your participation in therapy. Please provide phone numbers and email where we may call you and leave a message.

Home /Cell Phone _____ Message? (please circle one) YES NO

Work Phone _____ Message? (please circle one) YES NO

E-mail, if we can send a message _____

The person listed below is either the legal parent/guardian of the minor child or the person responsible for payment of this account. **If you are responsible for payment, you do not need to repeat any information given above.**

Name _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Work Phone _____ Home Phone _____ Cell Phone _____

My signature below indicates my acceptance of responsibility for this account.

Printed name _____ Signature _____ Date _____

WHAT CONCERNS THAT BRING YOU TO THERAPY?
(please describe your presenting problem)

ABOUT YOUR HEALTH

Please list any chronic or acute conditions that you experience in the space below:

If you are currently under the care of a doctor, please explain:

Have you recently been hospitalized for any reason? (Circle One) YES NO

If yes please explain:

Please list any medications that you are currently taking for any medical condition:

Have you been prescribed any psychotropic drugs by your physician/ psychiatrist? YES NO

Do you smoke cigarettes? (Circle One)	YES	NO	How often?
Do you use recreational drugs? (Circle One)	YES	NO	How often?
Do you drink alcohol? (Circle One)	YES	NO	What quantity per week? _____
Do you read/watch pornography? (Circle One)	YES	NO	How often?

ABOUT YOUR RELATIONSHIPS

1. If you are in a marriage, partnership or committed dating relationship, please answer the following questions:
 - a. Spouse/partner's name _____
 - b. Length of marriage/relationship _____
2. If you have children, please complete the table below:

Name of child	Gender	Age	Who does the child live with?

3. Please describe your family in the space below.

ABOUT YOUR FAMILY

Name of Relative	Living? Yes/No	Age or Age at Death	Live close to you?	Quality of relationship
Father				
Mother				
Sister(s)				
Brother(s)				
Other Significant Persons				

INFORMATION ABOUT ABUSE, SUICIDE OR HOMICIDEHistory of Abuse (Check all that apply):

Verbal _____ Neglect _____ Domestic _____
 Sexual _____ Elder _____
 Physical _____ Child _____

1. As a child did you experience physical abuse? (circle one) YES NO
If yes, did you receive treatment for this abuse?
2. As a child did you experience sexual abuse? (Circle one) YES NO
If yes, did you receive treatment for this abuse?

History of Suicide:

Have you had any thoughts, even once, in the past few days or weeks of, committing suicide or harmed yourself in any way? (Check one) Yes No

Do you have a plan for committing suicide or harming yourself in any way? (Check one) Yes No

Have you had the means (weapon, drugs, etc.) of carrying out your plan? (Check one) Yes No

Have you ever attempted suicide or harmed yourself in any way? (Check one) Yes No

History of Homicidal thoughts:

Are you having any thoughts about harming anyone else in any way? (Check one) Yes No

NOTICE: The student therapists and the CFTC staff are mandated by Texas law to report any of the following: elder or child abuse, threats or plans of committing harm to another person, and threats or plans of suicide by our clients.

Thank you for providing this information on you and your family.