



## CONCERNS THAT BRING YOU TO THERAPY

Please use this space to describe the issues, concerns, or problems that bring you to therapy.

### Client Demographic Information

Client's name \_\_\_\_\_

If client is a minor, please provide name(s) of parent(s) or guardian:

Client's age at last birthday \_\_\_\_\_

Date of Birth \_\_\_\_\_

Check one answer for each question below:

Male       Female

Black       Caucasian       Hispanic       Other \_\_\_\_\_

Married     Partner     Divorced     Widowed

Committed Dating Relationship     Single, living alone

Education: What is your highest degree or grade in school? \_\_\_\_\_

Occupation: \_\_\_\_\_ Years with this employer \_\_\_\_\_

**ABOUT YOUR HEALTH**

Name of your doctor \_\_\_\_\_ Last visit? \_\_\_\_\_

List any chronic medical issues \_\_\_\_\_

Have you been hospitalized for any reason? (circle one) YES NO

What was the date and reason for the hospitalization: \_\_\_\_\_

Have you been given a mental health diagnosis? If so, please describe:  
\_\_\_\_\_

Are you under the care of a psychiatrist? (circle one) YES NO

If so, whom \_\_\_\_\_

Have you been prescribed any psychotropic drugs by your psychiatrist? (circle one answer) YES NO

List all medications or drugs (legal or illegal) you have taken in the last year:

**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 \_\_\_\_\_

c. Name, gender, and age of children and their living situation:

Name	Gender	Age	Living in home/out of home?

2. If you have other important social relationships that are relevant to your treatment, please describe 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				

### FAMILY HISTORY

**In this space, please describe both your family of origin (parents) and your current family with emphasis on the quality of your relationships and important events that occurred in both families.**

**INFORMATION ABOUT ABUSE, SUICIDE OR HOMICIDE**

History of Abuse:

verbal _____	physical _____	sexual _____
marital _____	elder _____	child _____
neglect _____	level of violence _____	

History of Suicide:

Have you ever attempted 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 any thoughts, even once, in the past few days or weeks, of suicide or harming 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

ANYTHING ELSE?

Is there anything else that you wish to share with us?

**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.**

**Revised: 1-2010**