

Identifying Information & Treatment Goals

Patient's Name: _____ Date: _____

Your Name & Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Which number would you prefer I use? _____ OK to leave messages? _____

Date of Birth: _____ Ethnicity: _____

Marital Status: _____

Who referred you? _____

Why are you seeking help for your relative at this time?

What are your goals in seeking help for your relative (please be as specific as possible)?

1. _____
2. _____
3. _____

If you achieved these goals, how would life be different for you and your family?

What have you already tried in addressing the current problem?

Is your relative currently diagnosed with a mental health condition? _____ Yes _____ No

If Yes, what is/are the diagnosis(es)? _____

Has your relative in the past been diagnosed with a mental health condition? _____ Yes _____ No

If Yes, what was/were the diagnosis(es)? _____

Does your relative have any addictions? _____ Yes _____ No

If Yes, please specify

Present & Past Concerns

Please check any that your relative has experienced – currently or in the past – & briefly describe:

Current Past

Symptom Concerns

- Anxiety _____
- Depression _____
- Bad Nerves _____
- Anger _____
- Stress related health problems _____
- Low Energy/Fatigue _____
- Appetite/Eating Problems _____
- Sleep Disturbance _____
- Obsessive/Ruminating Thoughts _____
- Compulsive/Ritualistic Behaviors _____
- Trouble thinking, concentrating, remembering _____
- Fears _____
- Hearing voices or seeing things that aren't there _____
- Odd thoughts or ideas that others find bizarre _____
- Racing Thoughts _____
- Thoughts of Death or Suicide _____
- Suicide Attempts _____
- Thoughts of Violence _____
- Alcohol Use _____
- Drug Use _____
- Other Addictions _____
- Eating Disorders _____
- Other _____

Social or Environmental Concerns

- Family Problems _____
- Relationship Problems _____
- Sexual Problems _____
- School/Work Problems _____
- Financial Problems _____
- Legal Problems _____
- Religious/Spiritual Problems _____
- Social Problems/Problems getting along with people _____

_____ Other _____

Background History

Please describe a little bit about your relative's childhood: _____

Did your relative experience any of the following?	Is there any <u>family history</u> of...
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Alcohol/ Drug Abuse
<input type="checkbox"/> Psychological Abuse (Verbal/Emotional Abuse)	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Neglect	
<input type="checkbox"/> Other Traumatic Events _____	

Any traumatic events in childhood that occurred outside the home _____

Any traumatic events in adulthood? _____

No history of abuse or traumatic events

Please describe your relative's school experience, including any history of learning difficulties, learning disorder, or behavior problems in school? _____

Please describe any work experience of your relative & how he/she handled it _____

In what hobbies, activities, volunteer work, etc. is your relative active in now or in the past? _____

Does your relative have any current or past medical conditions (If so, please describe condition & treatment)?

Impact of the Condition

Please describe your relative's experience when the condition for which you are now seeking help first onset?

Please describe how the condition has impaired your relative's life (e.g., school/work, relationships, self-care)?

Please describe how the condition has affected your relationship with your relative?

Resources

Traditional Treatments

Please check any of those your relative has used – currently or in the past – and rate how helpful it has been.

Rate 0-10: 0 = not at all → 10 = extremely

Current Past Rate
 _____ **Psychotherapy** _____

Approximate dates & type: _____

_____ **Psychiatric Medications** _____

Current Psychiatrist & Phone Number _____

Current Meds & Dosage: _____

Past Medications used: _____

_____ **12 Step Programs** _____

Approximate dates & type of program: _____

_____ **None of the above**

Have you ever had a psychiatric hospitalization? _____ Yes _____ No

If YES, approximate dates & name of hospital(s): _____

Have you ever been in a residential treatment program? _____ Yes _____ No

If YES, approximate dates & name of program(s): _____

Complementary and/or Alternative Treatments:

Please check any of those your relative has used – currently or in the past – and rate how helpful it has been.

Rate 0-10: 0 = not at all → 10 = extremely

Current	Past		Rate	Current	Past		Rate
_____	_____	Herbs (e.g., St. John’s Wort)	_____	_____	_____	Homeopathy	_____
_____	_____	Yoga/Pilates/Tai Chi	_____	_____	_____	Exercise	_____
_____	_____	Chinese Medicine	_____	_____	_____	Acupuncture	_____
_____	_____	Meditation	_____	_____	_____	Chiropractic	_____
_____	_____	Relaxation Exercises	_____	_____	_____	Prayer	_____
_____	_____	Other: _____	_____				_____
_____	_____	None					

Religion & Spirituality:

Is your relative a religious or spiritual person? _____

How important is faith, spirituality or religion to him/her (Rate 0-10: 0 = not at all; 10 = extremely)? _____

What faith is your relative? _____

Is he/she a member of a spiritual or religious community or church? _____

Impact on the Family

While the condition affects the person, it is a trauma for the entire family. It is important to keep you and your family strong as you are getting help for your relative. The following apply to you and your immediate family – not your relative for whom you are seeking help.

Please describe your & your family's experience when the condition for which you are now seeking help first onset? _____

What are the most significant impacts that this condition has had on you and your family's life?

Please check any that you or another immediate family member has experienced in coping with your relative's condition & describe

You	Family Member	
_____	_____	Stress _____
_____	_____	Depression _____
_____	_____	Anxiety _____
_____	_____	Increased drinking, drug use or other addictive behavior _____
_____	_____	Stress related health problems _____
_____	_____	Relationship/Marital Problems _____
_____	_____	Impaired Work Performance _____
_____	_____	Other: _____

Coping & Supports:

What supports have you and your family sought in coping with your relative's condition (e.g. books, support groups, professional help) ? _____

What supports do you utilize for your own health (e.g., exercise, social activities, church, talking with family/others) ? _____

The Final Word

Is there anything else that you would like me to know about you as we begin our work together?

