Case History

Name_____ DOB_____ Today's Date _____

List symptoms you are experiencing, when they first started and how long they have lasted:

_____

_____

Please provide your Mental Health History, previous treatment, with whom and for how long?

_____

_____

Family Members with Mental Health Concerns: _____

Education, highest level achieved: _____

Current Job Status: _____How long?_____

Medical history, current health: _____

_____

Medications, Dose: _____

_____

Herbals, Dose: _____

_____

Allergies: _____

Alcohol Use (amount, frequency):_____

Cigarettes, cigar, other tobacco use (amount, frequency): _____

_____

Recreational Drug Use (What, Amount, Frequency, Age of initial use): _____

Have you missed work due to drug use or drinking? _____ Have others expressed concern about your drug use or drinking?_____

Please List your Hobbies, Interests and Recreational activities:

_____

_____

Spiritual Preferences:

_____

What do you hope to accomplish from your therapy?

_____

_____

Personal Physician: _____

Address: _____ City: _____ State: _____ Zip:_____

Patient'sSignature:_____Date:_____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

|_____|

Please place and "X" on the line above to indicate level of problem.

Therapist's Signature: _____Date:_____