LOCHMERE FAMILY COUNSELING

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Patient Data

Date: _____

Patient Name _____ **Date of Birth** _____ **Age** ____
(Last) (First) (Initial) (Maiden Name)

Address _____

City _____ State _____ Zip_____

Telephone _____ _____ _____
(Home) (Office) (Other: fax, cellular, or pager)

Email Address: _____

Occupation or School and Grade _____ Employer _____

Marital Status: Single ___ Married ___ Divorced ____ Separated ____ Widowed ____

Name of Spouse or Partner _____ Home Phone _____ Work_____ Cell _____

Children (or siblings if minor patient) Names / Ages / Grade _____

_____

Emergency Contact Person _____ Phone (Home) _____ (Other) _____

Referred by _____

Please complete the following if the patient is a minor:

Mother/Female Guardian

Name _____ Age ____

Address _____

Telephone Home _____

Office _____

Other (fax, cell, pager) _____

_____

Occupation & Employer _____

_____

Father/Male Guardian

_____ Age ____

_____

Home _____

Office _____

Other (fax, cell, pager) _____

_____

Occupation & Employer_____

_____

Patient's Physician(s) and Telephone (please list all, i.e., PCP, psychiatrist, neurologist, etc.)_____

_____

Patient History

Have you ever seen a mental health professional? Yes ____ No ____

Who? _____ When? _____ # of sessions _____

Have you ever had a hospitalization? Yes ____ No ____
(include medical/psychiatric/chemical dependency)

Where? _____ When? _____ # of days/weeks _____

Have you ever tried to commit suicide? Yes ____ No ____

How? _____ When? _____ # of attempts _____

Has any family member ever had a psychiatric condition? Yes ____ No ____

What family member? _____ What condition? _____

Do you have any current illnesses? Yes ____ No ____

What illnesses? _____ How long? _____

Are you currently taking medications? (attach separate sheet if needed) Yes ____ No ____

Medication _____ Date Started_____ Dosage _____ Reason _____
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Are you currently under the care of a physician? Yes ____ No ____

Name _____ Phone _____ Reason _____

How many cups of caffeinated coffee/tea do you drink per day? _____

How many caffeinated soft drinks do you drink per day? _____

How many pieces of chocolate/cups of cocoa do you drink per day? _____

Do you smoke? Yes ____ No ____

How much per day? _____ How long? _____

Do you use alcohol? Yes ____ No ____

How often? Never _____ Daily _____ Times per week_____ Times per month _____

When you drink alcohol, how many drinks do you normally consume? <2 ____ 2 to 5 ____ >5 ____

Do you feel you have a problem with alcohol? Yes ____ No ____

Have you ever had a problem with a substance (alcohol, drugs, prescription/nonprescription medications, etc.)? Yes ____ No ____

Substance(s) _____ When? _____ How much/often? _____

Do you feel you have a current problem with alcohol? Yes ____ No ____

Has anyone in your family had a problem with a substance? Yes ____ No ____

Who? _____

Have you experienced significant trauma in the past (rape, Sexual abuse, physical abuse, personal injury, accident, death, War, etc.)? Yes ____ No ____

What type? _____

Are you currently involved or planning to be involved in any Legal proceedings? Yes ____ No ____

Reason for visit (describe the problem/issue) _____

_____

_____

Check all that apply:

___ Acute or Chronic Illness _____
___ Adolescent Problem
___ Abortion Issue
___ Adoption Issue
___ Adult Child of Alcoholic (ACOA)
___ Adult Survivor of Sexual/Physical Abuse
___ Anxiety/Panic
___ Chronic Pain
___ Cultural/Race Issue
___ Depression
___ Domestic Violence
___ Dissociation
___ Eating Problem _____
___ Family Problem _____
___ Gay/Lesbian Issue
___ Grief/Bereavement
___ Incest Survivor
___ Infertility
___ Loss
___ Learning Disabilities/ADD _____

____ Marital/Partner Problem
____ Menopause
____ Miscarriage
____ Parenting Problem
____ Phobia _____
____ Postpartum Reaction
____ Post Traumatic Stress
____ Pregnancy/Childbirth Issues
____ PMS
____ Rape
____ Schizophrenia
____ Separation/Divorce
____ Sexual Abuse
____ Suicide Thoughts/Plan
____ Surgery _____
____ Step-Parenting Problem
____ Stress Management/Burnout
____ Substance Problem
____ Work-Related Problem
____ Other

To what extent are you experiencing Difficulty in the area of:	None	Little	Moderate	Quite A Bit	Extreme	How Long? (wks, mos, yrs)
Emotions/Mood (crying spell, outburst of anger, etc.)	____	____	____	____	____	____
Thinking (negative thoughts about self, pessimism, worry, obsessions, suicide, etc.)	____	____	____	____	____	____
Memory (remembering vital information like deadlines, assignments, name, dates; misplacing items, etc.)	____	____	____	____	____	____
Concentration (daydreaming, following instructions, getting confused, etc.)	____	____	____	____	____	____
Perception (determining if something is real, etc.)	____	____	____	____	____	____
Interest/Motivation (in usual activities, people, etc.)	____	____	____	____	____	____
Behavior (hand washing, getting things in order, eating, drinking, using drugs/ medications, gambling, spending, hurting self, etc.)	____	____	____	____	____	____
Physical Health (developing physical symptoms, physical condition getting worse, etc.)	____	____	____	____	____	____
Sleep (getting up in the morning, falling asleep, staying asleep, nightmares, etc.)	____	____	____	____	____	____
Appetite (Loss or increased appetite)	____	____	____	____	____	____
Sexual Activity (Loss of interest, fear, out of control, etc.)	____	____	____	____	____	____
Social Activity (staying home alone, difficulty making friends, etc.)	____	____	____	____	____	____
Relationships						
Getting along with teacher/boss	____	____	____	____	____	____
Getting along with friends	____	____	____	____	____	____
Getting along with spouse/partner	____	____	____	____	____	____
Getting along with family members	____	____	____	____	____	____
School (absenteeism, lateness, cutting classes, not completing homework, failing, etc.)	____	____	____	____	____	____
Work (finding/keeping a job, absenteeism, lateness, not completing assignments, etc.)	____	____	____	____	____	____
Other: _____	____	____	____	____	____	____