San Gabriel Independent Therapists

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Client Name: ________________________________ DOB: _________________________-

Primary Care Doctor: __________________________________ Phone: ____________________________

Specialist Doctor: ____________________________________ Phone: ____________________________

Other Treatment Provider chiropractor, nutritionist, acupuncturist: ____

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Illnesses, Conditions, or previous Diagnosis Physical or Mental: ____

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Current Medications and Dosages: ____

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Previous mental health Medications: ____

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What prompted you to call for an appointment? ____

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How were you referred: ____

Have you ever been hospitalized, Physical or Mental: ____

____

Any History of abuse? Please Circle Physical Emotional Sexual Emotional Neglect

Have you suffered a traumatic event? Ex. Car Crash, Hurricane, Deployed Military Service, Assault… _____________

____

Significant Losses in your life and year: ____

____

Do you feel like you have resolved these issues? How? ____

Any family history of mental illness? Please circle and indicate what relation: _________________________________

Anxiety Depression Bipolar ADHD Schizophrenia Learning Differences

Any family history of substance abuse or addiction? If yes, what relation and substance: _______________________

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Are there any possible legal issues or court action which is related to you or could be related to your treatment? Yes No

If Yes, Please explain: ____

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Signature: ________________________________ Date: _____________________________