Family Therapy Clinic

8480 Bluebonnet Blvd, Suite A
Baton Rouge, LA 70810-2879
Tel: (225) 292-0155 Fax: (225) 292-0157

Background and History

Patient Name_____ Age_____ □ Single □ Married □ Divorced □ Widowed
Street Address_____ Phone_____
City_____ , State_____ Zip_____
□ Live alone □ Live w/others (list)_____
□ In school (name/grade)_____ □ n/a
□ Working (employer/position)_____ □ n/a

Presenting Concerns:_____
_____
_____

Please check the following if you are experiencing symptoms **Currently** (**C**) or have experienced them in the **Past** (**P**) *(leave boxes blank if not applicable)*

C / P	C / P	C / P	C / P
Psychological	**Physical**	**Behavioral**	**Social**
□ □ Sadness	□ □ Insomnia	□ □ Procrastination	□ □ Social Discomfort/Anxiety
□ □ Frequent Crying	□ □ Chronic Pain	□ □ Violent Behavior	□ □ Social Phobia
□ □ Loss of Hope	□ □ Fatigue	□ □ Compulsive Spending	□ □ Low Self-Confidence
□ □ Decreased Interest in Previously Enjoyed Activities	□ □ Heart Palpitations	□ □ Compulsive Gambling	□ □ Low Assertiveness
	□ □ Appetite Decrease w/Weight Loss	□ □ Impulsivity	□ □ Low Social Support
□ □ Social Withdrawal	□ □ Appetite Increase w/Weight Gain	□ □ Fidgety	
□ □ Suicidal Thoughts		□ □ Disorganization	**Substance**
□ □ Homicidal Thoughts	**Educational**	□ □ Frequently Losing Things (e.g., keys, phone, glasses)	□ □ Alcohol Occasional/Social Use
□ □ Paranoia	□ □ Poor Grades		□ □ Alcohol Frequent Use
□ □ Hallucinations	□ □ Poor Test Taking		□ □ Alcohol Dependence
□ □ Chronic Worry	□ □ Poor Reading Comprehension	**Neurological**	□ □ Cannabis Occasional/Social Use
□ □ Anxiety/Nervousness		□ □ Headaches	□ □ Cannabis Frequent Use
□ □ Panic Attacks	□ □ Poor Phonics	□ □ Dizziness	□ □ Cannabis Dependence
□ □ Phobias	□ □ Poor Spelling	□ □ Seizures	□ □ Opioid Abuse/Dependence
□ □ Traumatic Stress	□ □ Poor Math	□ □ Loss of Sensation/Numbness	□ □ Stimulant Abuse/Dependence
□ □ Obsessive-Compulsive Problems	□ □ Poor Handwriting	□ □ Vertigo	□ □ Tobacco Light Use
	□ □ Letter/Word Reversal	□ □ Memory Problems	□ □ Tobacco Heavy Use
□ □ Bulimia, Anorexia or Other Eating Disorder	□ □ Difficulty w/Verbal or Written Expression	□ □ Attention/Concentration Problems	□ □ Other Substance Abuse

Treatment History: □ No Previous Treatment

Please list any past **mental health** or **psychiatric** treatments including counseling, medication, and hospitalizations

Treatment Description	Dates (Duration)

Medical History:

Current Height_____ Current Weight_____
Developmental Delays (list)_____
_____
Primary Care Physician_____ Phone_____
Pharmacy_____ Phone_____ Zip_____

Please list **other** current providers of your **medical** or **mental health** care, and specialty *(e.g., cardiologist, ob/gyn, psychiatrist, counselor)*	
Provider Name	**Specialty**

Please check the following if you are experiencing symptoms **Currently** (**C**) or have experienced them in the **Past** (**P**) *(leave boxes blank if not applicable)*

C / P	C / P	C / P	C / P
Gastrointestinal	**Metabolic/Endocrine**	**Genitourinary**	**Respiratory**
□ □ Irritable Bowel Syndrome (IBS)	□ □ Type 1 Diabetes	□ □ Kidney Stones	□ □ Asthma
□ □ Crohn's/Ulcerative Colitis	□ □ Type 2 Diabetes	□ □ Gout	□ □ Chronic Sinusitis
□ □ Gastritis or Peptic Ulcer Disease	□ □ Hypoglycemia	□ □ Interstitial Cystitis	□ □ Sleep Apnea
□ □ GERD (reflux)	□ □ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)	□ □ Frequent Urinary Tract Infections	□ □ Bronchitis
□ □ Celiac Disease or Gluten Intolerance	□ □ Hypothyroidism	□ □ Kidney Disease	□ □ Emphysema
□ □ Liver Disease	□ □ Hyperthyroidism	□ □ Other_____	□ □ Pneumonia
□ □ Other_____	□ □ Polycystic Ovarian Syndrome (PCOS)		□ □ Other_____
	□ □ Infertility	**Musculoskeletal**	
Cardiovascular	□ □ Other_____	□ □ Osteoarthritis	**Skin**
□ □ Heart Attack		□ □ Fibromyalgia	□ □ Eczema
□ □ Other Heart Disease	**Cancer**	□ □ Chronic Pain Condition	□ □ Psoriasis
□ □ Arrhythmia (irregular heart rate)	□ □ Lung Cancer	□ □ Other_____	□ □ Acne
□ □ Pacemaker	□ □ Breast Cancer		□ □ Other_____
□ □ Stroke	□ □ Colon Cancer	**Inflammatory/Autoimmune**	
□ □ Elevated Cholesterol	□ □ Ovarian Cancer	□ □ Chronic Fatigue Syndrome	**Neurological**
□ □ Hypertension	□ □ Prostate Cancer	□ □ Rheumatoid Arthritis	□ □ Chronic Headaches
□ □ Blood Clots	□ □ Skin Cancer	□ □ Lupus	□ □ Migraines
□ □ Blood Thinners	□ □ Other_____	□ □ Hepatitis	□ □ Alzheimer's Disease
□ □ Other_____		□ □ Chronic Food/Environmental Allergies	□ □ Parkinson's Disease
		□ □ AIDS/HIV	□ □ Multiple Sclerosis
		□ □ Other_____	□ □ Seizures
			□ □ Other_____

Please list any past surgical procedures	
Surgical Procedure	**Date**

Current Medications: □ No Current Medication

Please list ALL medications that you regularly take including prescriptions, over-the-counter, herbals, & nutritional supplements *(list additional medications on back)*		
Medication Name	**Dose**	**How & When Taken** *(e.g., by mouth twice a day; sublingually in the morning; apply patch at bedtime)*

□ No Known Drug/Food Allergies Allergies_____

Females Only: Possibly pregnant? □ Yes □ No *(If Yes, _____ weeks pregnant)*
Use of birth control? □ Yes □ No *(If Yes, list type _____)*

Family History: □ No Family History

Please list any **medical** or **mental health** conditions for your close family members	
Relationship	**Conditions**
Mother	
Father	
Maternal Grandparents	
Paternal Grandparents	
Sister/s	
Brother/s	

Any Additional Concerns/Information:_____

_____

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