Office of Elizabeth Dear, MFT, LCADC
527 Plumas St, Reno, NV 89509
Ph/fax 775-348-4696

Brief Personal History (Adult)

Date of first session: _____

Name_____ Birthdate_____

Address_____

Preferred phone_____ Best times to reach you: _____

Ok to leave message? yes ○ no ○

Employer_____Occupation_____

Emergency Contact with phone number:

_____

Family History

Single ○ _____Live-in Partner ○ _____Married ○ _____(1st/ 2nd/ 3rd) Widowed ○ _____

Spouse's Name_____Spouse's Birthdate _____

Separated____Divorced _____Date of Separation/Divorce_____(1st/ 2nd/3rd)

Custody arrangement:_____(Physical and legal)

Person(s) with whom living (Significant Other/Roommate)_____

Children's Names_____ Ages _____

Siblings' Names_____ Ages _____

Mother's Name, age, and health/living status:_____

Father's Name, age, and health/living status:_____

Other significant caregivers: _____

Religious Preference/Affiliation_____

Gender Identity:_____Sexual Orientation:_____

Education (level completed, significant factors): _____

Military History:_____

Medical History

Personal Physician_____Phone_____

Address (at least city) _____

Current Medications and Dosages _____

Date of last Medical Exam, and any significant current health issues?_____

_____

Significant past medical/health events:_____

_____

_____

Have you been in psychotherapy before?_____approximate dates:_____

With whom and where?_____

Please write on the reverse if there's not enough space here for any answer.

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How would you describe your prior therapy? _____

_____

What brings you to therapy now?_____

_____

What do you view as your greatest strengths?_____

_____

Please circle any of the following with which you're currently having difficulty:

sleep eating energy thoughts of suicide mood sex drive motivation nightmares

anxiety panic attacks alcohol or drug abuse intrusive thoughts compulsive behavior

Please describe current stressors in your life: _____

_____

_____

What significant losses have you experienced in the last 2-5 years? _____

_____

_____

How much alcohol (if any) do you usually drink per week? _____

How much of other drugs, including over prescribed dosage of medications, do you usually use per day?

_____

Do you see your alcohol or drug use as a problem? _____Does anyone else?_____

Please describe any family history of psychiatric issues, suicide attempts, or drug/alcohol problems:

_____

_____

_____

_____

What, if any, traumatic experiences have you had at any time in life? _____

_____

What else would you like me to know? _____

_____

What would you like to gain from therapy?_____

_____

Who referred you to me or how did you find out about my practice? _____
May I thank the person who referred you? _____

Please write on the reverse if there's not enough space here for any answer.