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| **Twin Cities Therapy and Counseling Associates, PLLC**5851 Duluth Street, Suite 306 Golden Valley, MN 55422PH: 612-202-8703 |
|  | Self Information Form |  |
|  | Adult |  |

Date:

**I. PERSONAL INFORMATION**

Name: Address:

Birth Date:

Household Size: Marital Status: Who referred you to us? Personal Physician:

Telephone Numbers:

Home: (Can a message be left?) (Y/N)

Work (Can a message be left?) (Y/N)

Cell:

Address/Telephone:

**II. PERSONAL HISTORY**

Birth Place: (City) (State)

Where else have you lived?

(City) (State)

Employment (Current):

(Position) (Company) (Length of Time) Employment (Past): Highest Level of Education Attained: Major medical problem or hospitalization: (List any additional on back)

(When) (Where) (Reason)

 physician ?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. FAMILY HISTORY**

Has there been any recent change to your health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse:** Name: Age: Length of Relationship:

Occupation: Highest Educational Level:

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you been married before: Yes No Has your spouse been married before? Yes No

**Children**: (Indicate if step) (List additional on back)

(Name) (Age) (Residence: Use "S" if same as yours)

**IV. PRESENT DIFFICULTY:**

Please check all symptoms you may be currently experiencing:

 Crying Spells

 Stomach Problems

 Impaired Concentration

 Change in Sex Drive

 Sleep Difficulties

How Long Ever Have Experiencing? Symptom Before?

 Feelings of Anxiety/Panic

 Change in Energy Level

 Other (elaborate below)

Using your own words, please describe the reason you are here:

How are you dealing with it now?

Have you ever been diagnosed with a mental health disorder? (If yes: by whom, when, and what diagnosis?)

Does today's difficulty involve alcohol/drug use (either your own or someone else's)?

 Yes No Please explain:

Does this situation involve a legal difficulty (either your own or someone else's)?

 Yes No Please explain:

Have you ever thought of harming yourself? Yes No Someone else? Yes No

Have you previously seen a therapist? Yes No

With whom?

When?

How long?

What are your goals for our work together?

# In case of emergency:

Contact: Phone: (H) (W) Address: Relationship:

#  Signature: Date