Iowa Specialty Hospitals & Clinics
Specializing in You

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Counseling & Therapy Services Patient Form

Personal Information

Name:____ Date:__________ Sex: _______________
Address: ____
Phone: ____ Email: _____________________________
DOB: _________________________
Primary Physician:____ Phone:______________________________
Current Therapist:____ Phone:______________________________

Complaint

What is your reason for seeking help?____
Start Date: _______________________________ Have you previously suffered from this complaint?_______________
Previous therapist(s) seen in the past:____
Who, Where, When, Was this beneficial?____
____

Current Symptoms (Check All That Apply & List All Others)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt/Shame
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Problems	☐ Trust Issues	☐ Bad Dreams	☐ Memory Issues
☐ Recurring Bad Dreams	☐ Hallucinations	☐ Headaches	☐ Anger
☐ Pain			

Medical History

Allergies:____
Current medications:____
Previous diagnoses:____
Previous medications(see pretreatment medication checklist):____
Previous medical conditions:____
Any previous loss of conciousness or head injuries:____
Dates treated:____
Previous surgeries: what & when:____

Family History

Were you adopted?________________________________ If yes, at what age?______________________________
How is your relationship with your mother?____
How is your relationship with your father?____
Siblings names and their ages:____
____
Are your parents married?____
Are your parents divorced?__________________________ If yes, how old were you?_________________________
Did your parents remarry?__________________________ If yes, how old were you?_________________________
Who raised you?____
Family member medical conditions:____
Family member mental conditions and substance abuse:____

Early Development

Where did you grow up?____________________
How often did you move and where?____________________
How old were you when you left home?____________________
Have any immediate family members died?______________ Who?____________________
When?____________________ How?____________________
Have any committed suicide?____________________ Who?____________________
Describe any neglect you suffered, and by whom:____________________
Highest education level completed:____________________
Date completed and location:____________________
Have you ever served in the military?____________________ If yes, where?____________________
Dates of service:____________________ Highest rank achieved:____________________

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Work History: ____________________ ____________________
Where:____________________ When:____________________
Marital Status:____________________ If yes, date of marriage:____________________
Prior marriages?____________________ If yes, how many?____________________
What is your sexual orientation?____________________ Partner Name: ____________________
Are you sexually active?____________________
How is your relationship with your partner?____________________
Do you have children?____________________ Names, Sex, Age:____________________
____
List anyone else who lives with you:____________________
Have you ever been arrested?____________________ When and why?____________________
Have You Ever Tried the Following? (Check All that Apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency/dates of use:____________________
____
Have you ever been treated for drug/alcohol abuse?_______ If yes, when?____________________
For which substances?____________________
Addictions: ☐ Food ☐ Sex ☐ Gambling
Do you smoke cigarettes?____________________ If yes, how many per day?____________________
Do you drink caffeinated beverages?____________________ If yes, how many per day?____________________

Anything Else You Want the Provider to Know

____
____
____
____
____
____
____

____________________ ____________________
Signature Date