

Case #: _____

Readmit? Yes No

PERSEPECTIVES OF TROY, P.C.

PARTNER RELATIONAL PERSONAL HISTORY INFORMATION

PLEASE PRINT CLEARLY

Today's Date: _____

Client's Last Name

First Name

M.I.

Street Address

Social Security Number

Date of Birth

City

State

Zip

Name of Spouse/Significant Other:

() _____

Client's Home Phone Number

() _____

Client's Work Phone Number

EMERGENCY CONTACTS:

Primary Physician: _____ Phone #: _____

Other: _____ Specialty: _____ Phone #: _____

EMPLOYMENT INFORMATION:

Employer: _____ Occupation: _____ Hrs. _____

REFERRAL SOURCE:

How did you hear of our clinic? _____

Address: _____

Phone Number: _____

To assist us in helping you, please fill out the attached information as fully and as openly as possible. Your answers will help plan the course of therapy that is most suitable for you and your significant other. Please do not collaborate with you significant other when completing this form. Please respond honestly and carefully to each item. If certain questions do not apply, please state that as your answer. Use the back of this form if necessary.

Please write a paragraph describing your life growing up. Include circumstances that effected your development: (child abuse, sexual abuse, inadequate nutrition, neglect, relocation, etc.)

SOCIAL INFORMATION

Describe how you relate to people (i.e. easily, shy, leader, follower, extrovert, etc...).

Who do you socialize with (immediate family, extended family, friends, co-workers, etc...)?

Who is your main source of emotional support (family, friend, co-worker, no one, etc.)

Do you and your significant other have the same friends? Yes No separate friends? Yes No

Do you isolate yourself from other people? Yes No

Explain: _____

Is your spouse included in your socialization? Yes No

Describe special interests or hobbies you may have (art, music, crafts, outdoor activity, church activity, books/films, physical fitness, diet/health, sports, etc.): _____

Has your activity level changed recently? Yes No If yes, please explain: _____

Do you feel the social aspect of your life has created conflict in your relationship? Yes No

Sexual Orientation (heterosexual, homosexual, bisexual): _____

List any sexual problems, concerns or difficulties you may be experiencing. _____

Do you feel this is an area of concern in your relationship? Yes No

SPIRITUAL/RELIGIOUS INFORMATION

Do you consider yourself a spiritual person? Yes No

What religion were you raised? _____

Do you practice a formal religion now? Yes No If yes, what religion? _____

Do you feel your spiritual/religious beliefs currently cause conflict in your relationship? Yes No

LEGAL INFORMATION

Current Legal Information

Are you involved in any active cases (traffic, civil, criminal): Yes No
If yes, please describe and indicate the court dates and charges:

Are you presently on probation or parole: Yes No
If yes, please describe: _____

Past Legal History: _____

Are you currently, or have you ever been, involved in any child custody cases? Yes No
If yes, please give further details regarding this: _____

Are you currently ordered to pay child support? Yes No

EDUCATION INFORMATION

Check all that apply:

- High school diploma/GED Currently enrolled: Last grade completed: _____
- Did not complete high school: Last grade completed: _____
- College: Currently enrolled: Number of years completed: _____ Degree earned: _____
- Vocational training: Currently enrolled: Training completed: Specialty: _____

Special circumstances (i.e. learning disabilities, gifted program, special education, etc...):

Do you feel the educational difference (if any) between you and your significant other have created conflict in your relationship? Yes No Explain: _____

EMPLOYMENT/VOCATIONAL INFORMATION

Beginning with most recent job, give employment history: (include homemaker experience)

Employer	Dates	Job Description	Salary

Total yearly income: \$ _____

Total family income: \$ _____

Special circumstance (laid off, self-employed, suspended, disabled, retired, social security, etc...)

Is your significant other employed? Yes No

If yes, please state their occupation: _____

Is employment a source of conflict in your relationship? Yes No

Are finances a source of conflict in your relationship? Yes No

PHYSICAL HEALTH INFORMATION

Check all that apply and describe below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Sexual Transmitted Diseases |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> HIV | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Other: _____ |

Explain: _____

Please list any current medications you are taking (prescription and over the counter):

Are you allergic to any medications or drugs: (describe) _____

	Date	Reason	Results
Last Physical			
Last doctor's visits			

List any surgeries and dates: _____

List any family history of medical problems: _____

Any recent changes in:

- | | | | |
|-----------------|--|------------------------------------|--|
| Sleep patterns | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical activity level | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eating patterns | <input type="checkbox"/> Yes <input type="checkbox"/> No | General disposition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Behavior | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Energy level | <input type="checkbox"/> Yes <input type="checkbox"/> No | Increase in nervousness or tension | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered yes to any of the above, please explain: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the Counter								
Prescription Drugs								
Other Drugs								

Substance of preference: _____

Does your significant other use drugs or substances of any kind? Yes No

COUNSELING/PRIOR TREATMENT INFORMATION

Information about yourself:

	Yes	No	When	Where	Briefly Describe
Relational/Marital Counseling					
Individual Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous)					

COUNSELING/PRIOR TREATMENT INFORMATION CONTINUED

Information about you significant other:

	Yes	No	When	Where	Briefly Describe
Relational/Marital Counseling					
Individual Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous)					

Information about you family:

	Yes	No	Family Member	Where	When	Briefly Describe
Relational/Marital Counseling						
Individual Counseling/Psychiatric Treatment						
Suicidal thoughts/attempts						
Drug/alcohol treatment						
Hospitalizations						
Involvement with self-help groups (i.e. AA, Al-Anon, NA, Overeaters Anonymous)						

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No

CLIENT SIGNATURE: _____

STAFF USE ONLY

The information contained within this form was reviewed and discussed with the patient as deemed necessary.

Therapist Signature/Credentials

Date