Tali Moskowitz, LCSW

Please provide me with some information about your medical health and the reason you're seeking care now. This will allow us to spend more time discussing your current issues, and less time asking you questions about historical data!

****Please Note: If there is any Information on the following pages you would prefer to review with me in person, please feel free to leave those portions blank****

PERSONAL HISTORY - ADULT

Client's name:_____ Date: ____/___ / ____

Sex: F ☐ M ☐ Date of birth: ____/___ / ____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City:_____

State:_____ Zip: _____

Phone (home): _____ Leave Message: Yes ☐ No ☐

Phone (work): _____ Leave Message: Yes ☐ No ☐

Phone (cell): _____ Leave Message: Yes ☐ No ☐

Emergency contact name: _____Phone: _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services:_____

Anger management ☐ Anxiety ☐ Coping ☐ Depression ☐ Eating disorder ☐
Fear/phobias ☐ Mental confusion ☐ Sexual concerns ☐ Sleeping problems ☐
Addictive behaviors ☐ Alcohol/drugs ☐

Other mental health concerns (specify): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes ☐ No ☐

If yes, previous therapist/practitioner: _____

Family Information

RELATIONSHIP	NAME	AGE	LIVING YES	LIVING No	LIVING WITH YOU Yes	LIVING WITH YOU No
Mother						
Father						
Spouse						
Child						
Child						
Child						
Child						
Child						

Significant others (e.g., brothers, sisters, (grand)parents, step-relatives, half-relatives. Please specify relationship and if living with you.

_____

_____

_____

_____

Marital Status (more than one answer may apply)

Single _____ Divorce in process_____ Length of time: _____

Unmarried, living together_____ Length of time: _____

Legally married_____ Length of time: _____

Separated_____ Length of time: _____

Divorced_____ Length of time: _____

Widowed _____ Length of time: _____

Annulment_____ Length of time: _____ Total number of marriages: _____

Assessment of current relationship (if applicable): Good Fair Poor

Anything you would like to discuss in particular:_____

_____

_____

_____

Parental Information

Parents legally married: _____

Mother remarried: _____

Number of times: _____

Parents have ever been separated : _____

Father remarried: _____

Number of times: _____

Parents ever divorced: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

_____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes ☐ No ☐

If Yes, please describe: _____

_____

_____

Has there been history of child abuse? Yes ☐ No ☐

If Yes, which type(s)? Sexual ☐ Physical ☐ Verbal ☐

If Yes, the abuse was as a: Victim ☐ Perpetrator ☐

Other childhood issues: Neglect ☐ Inadequate nutrition ☐

Other (please specify): _____

Comments re: childhood development: _____

_____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ☐ Follower ☐

Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive ☐

Other (specify): _____

Sexual orientation: _____Comments:_____

Sexual dysfunctions? Yes ☐ No ☐

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes ☐ No ☐

If Yes, describe: _____

Spiritual/Religious

How important to you are spiritual matters? _____

Are you affiliated with a spiritual or religious group? Yes ☐ No ☐

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes ☐ No ☐

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes ☐ No ☐

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? Yes ☐ No ☐

If Yes, please describe and indicate the court and hearing/trial dates and charges:

_____

_____

Are you presently on probation or parole? Yes ☐ No ☐

If Yes, please describe: _____

Past History

Traffic violations: Yes ☐ No ☐ DWI, DUI, etc.: Yes ☐ No ☐

Criminal involvement: Yes ☐ No ☐ Civil involvement: Yes ☐ No ☐

If you responded Yes to any of the above, please fill in the following information.

Charges_____ Date_____

Where _____

Results_____

Education (Fill in all that apply):

Years of education:_____ Currently enrolled in school? Yes ☐ No ☐

High school grad/GED Yes ☐ No ☐

Vocational: _____Number of years: _____Graduated: Yes ☐ No ☐

Major: _____

College: _____Number of years: _____Graduated: Yes ☐ No ☐

Major: _____

Graduate:_____ Number of years: _____Graduated: Yes ☐ No ☐

Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer_____ Dates _____Title _____

Reason left the job_____How often miss work?_____

Employer_____ Dates _____Title _____

Reason left the job_____How often miss work?_____

Employer_____ Dates _____Title _____

Reason left the job_____How often miss work?_____

Currently: FT ☐ PT ☐ Temp ☐ Laid-off ☐ Disabled ☐ Retired ☐

Social Security /Student/ Other (describe): _____

Military

Military experience? Yes ☐ No ☐ Combat experience? Yes ☐ No ☐

Where: _____

Branch: _____Discharge date: _____

Date drafted:_____ Type of discharge: _____

Date enlisted: _____Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

_____

_____

_____

Activity_____ How often now?_____ How often in the past?_____

Activity_____ How often now?_____ How often in the past?_____

Activity_____ How often now?_____ How often in the past?_____

Medical/Physical Health (Please check all that apply)

AIDS ☐ Dizziness ☐ Nose bleeds ☐ Alcoholism ☐ Drug abuse ☐ Pneumonia ☐

Abdominal pain ☐ Epilepsy ☐ Rheumatic Fever ☐ Abortion ☐ Ear infections ☐

Sexually transmitted diseases ☐ Allergies ☐ Eating problems ☐ Sleeping disorders ☐

Anemia ☐ Fainting ☐ Sore throat ☐ Appendicitis ☐ Fatigue ☐ Scarlet Fever ☐

Arthritis ☐ Frequent urination ☐ Sinusitis ☐ Asthma ☐ Headaches ☐ Smallpox ☐

Bronchitis ☐ Hearing problems ☐ Stroke ☐ Bed wetting ☐ Hepatitis ☐ Sexual problems ☐

Cancer ☐ High blood pressure ☐ Tonsillitis ☐ Chest pain ☐ Kidney problems ☐

Tuberculosis ☐ Chronic pain ☐ Measles ☐ Toothache ☐ Cols/Coughs ☐ Mononucleosis ☐

Thyroid problems ☐ Constipation ☐ Mumps ☐ Vision problems ☐ Chicken Pox ☐

Menstrual pain ☐ Vomiting ☐ Dental problems ☐ Miscarriage ☐ Whooping cough ☐

Diabetes ☐ Neurological disorders ☐ Diarrhea ☐ Nausea ☐

Other (describe):

_____

_____

List any current health concerns:

_____

_____

List any recent health or physical changes:

_____

_____

Nutrition

Typical foods eaten _____

Typical amount eaten_____

(times per week)

Breakfast _____Lunch _____Dinner _____

Snacks _____

Comments:_____

General Medical

Current prescribed medications	Dosage	Dates Taken	Purpose	Side Effects

Current Over the Counter medications	Dosage	Dates Taken	Purpose	Side Effects

Have you ever been prescribed psychiatric medication? Yes ☐ No ☐

Please list and provide dates: _____

_____

Are you allergic to any medications or drugs? Yes ☐ No ☐ If Yes, describe: _____

Most recent examinations _____Date _____Reason_____

Results_____

Last physical exam_____

Last doctor's visit_____

Last Gyn visit_____

Last vision exam_____

Last hearing exam_____

Most recent surgery_____

Other surgery_____

Upcoming surgery_____

Family history of medical problems:

_____

_____

Please check if there have been any recent changes in the following:

Sleep patterns ☐ Eating patterns ☐ Behavior ☐ Energy level ☐

Physical activity level ☐ General disposition ☐ Weight ☐ Nervousness/tension ☐

Describe changes in areas in which you checked above:

_____

_____

Chemical Use History

Method	Age Began Use	Frequency	Amount	Last Used	30 Days YES/NO		48 Hours YES/NO	
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Other drugs:								

Substance Abuse Questions

Describe when and where you typically use substances:

_____

_____

Describe any changes in your use patterns:

_____

Describe how your use has affected your family or friends (include their perceptions of your use):

_____

_____

Reason(s) for use:_____

Addicted ☐ Build confidence ☐ Escape ☐ Self-medication ☐ Socialization ☐ Taste ☐

Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?_____

If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes ☐ No ☐

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol?
(describe):_____

Have drugs or alcohol created a problem for your job? Yes ☐ No ☐

If Yes, describe: _____

Counseling/Prior Treatment History

Counseling/Psychiatric treatment Yes ☐ No ☐

Suicidal thoughts/attempts Yes ☐ No ☐

Drug/alcohol treatment Yes ☐ No ☐

Hospitalizations Yes ☐ No ☐

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) Yes ☐ No ☐

Information about family/significant others (past and present):

Counseling/Psychiatric treatment Yes ☐ No ☐

Suicidal thoughts/attempts Yes ☐ No ☐

Drug/alcohol treatment Yes ☐ No ☐

Hospitalizations Yes ☐ No ☐

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) Yes ☐ No ☐

Please check behaviors and symptoms that occur to you more often than you would like:

Aggression ☐ Elevated mood ☐ Phobias/fears ☐ Alcohol dependence ☐ Fatigue ☐

Recurring thoughts ☐ Anger ☐ Gambling ☐ Sexual addiction ☐ Antisocial behavior ☐

Hallucinations ☐ Sexual difficulties ☐ Anxiety ☐ Heart palpitations ☐ Sick often ☐

Avoiding people ☐ High blood pressure ☐ Sleeping problems ☐ Chest pain ☐ Hopelessness ☐

Speech problems ☐ Cyber addiction ☐ Impulsivity ☐ Suicidal thoughts ☐ Depression ☐

Irritability ☐ Thoughts disorganized ☐ Disorientation ☐ Judgment errors ☐ Trembling ☐

Distractibility ☐ Loneliness ☐ Withdrawing ☐ Dizziness ☐ Memory impairment ☐ Worrying ☐

Drug dependence ☐ Mood shifts ☐ Eating disorder ☐ Panic attacks ☐

Other (specify):

_____

Briefly discuss how those symptoms impair your ability to function effectively:

_____

_____

_____

_____

_____

Any additional information that would assist in understanding your concerns or problems:

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____

_____

Do you feel suicidal at this time? Yes ☐ No ☐

If Yes, explain:

_____

_____

Please be advised that if you are feeling suicidal, you should call 911 or go to your nearest emergency room immediately. Do not wait.

You can reach the Suicide Prevention Hotline Here: 1-800-273-TALK (8255)

Is there any addition information that you would like me to know?

_____

_____

_____

_____

_____

_____

_____

_____