Lori Little, MA, Psychotherapist

Name of client:_____ Date:_____

SS#_____

If a child, parent's name including step-parents:_____

Address:_____ City:_____

Zip:_____

Home Phone():_____ Cell:()_____

Bus.()_____

Gender:_____ Race:_____ Religion:_____

Employed?_____ Employer:_____

Employer Address:_____

Position:_____ Duration:_____

Date of Birth:_____ Age:_____

Referred by:_____
Yodle:_____ Physician:_____ Yahoo:____ Google:_____ Bing:_____ MSN:_____
Yellow pages:_____ Friend(Who):_____

What is your reason for seeking treatment at this time?_____

_____

What would you like to achieve from treatment?_____

How long do you think it will take to resolve this issue/problem?_____

_____

Describe your strengths:_____

List family or friends you would like involved in your treatment:_____

Are family and friends aware of your decision to come here?_____

Family History

Mothers age:_____ Deceased, your age:_____ Her age at birth:_____

Occupation:_____ Fathers age:_____ Deceased, your age:_____

His age at your birth:_____ Occupation:_____

Number of brothers:_____ Sisters:_____

Deceased, who? And your age then:_____

Number of half brothers:_____ Sisters:_____ On who's side?_____

Parents divorced:_____ If yes, your age, then:_____

Your age when Mother remarried:_____ Age when Father remarried:_____

Who do you live with?_____

Who raised you:_____ Your place in birth order:_____

Where were you born?_____

Describe your relationship with your:

Mother:_____

Father:_____

Brothers:_____

Sisters:_____

Stepmother:_____

Stepfather:_____

Stepsiblings:_____

Half Siblings:_____

Grandparents:_____

Culture, Ethnicity, Spirituality, Religion

Describe any cultural, ethical, or religious concerns that might influence your treatment:_____

Does spirituality influence your life?_____

Religious Preference:_____ Active?_____

Limitations Affecting Treatment:
Do you have a disability or limitation which may affect your ability to participate in treatment services, ie. Visual or auditory impairments?_____

Is your primary language English?_____ If No what is?_____

Childhood Development

Did you have serious illnesses/problems or injuries as a child?
No?_____ Yes?_____
Please explain:_____

Abuse History

Have you ever been physically, emotionally, or sexually abused?_____

If Yes, was it reported?_____

How old were you at the time of the abuse? Who was/were the perpetrator(s)?_____

Have you ever abused another person? If yes, how and when?_____

Relationships

Are you currently in a relationship?_____ Duration:_____

Are you sexually active?_____ What is your sexual orientation?_____

Hetero:_____ Homo:_____ Bi:_____

Are you comfortable with your sexuality?_____

Are you comfortable with your gender?_____

If No to either, please explain:_____

List all past and significant relationships/marriages: age, duration, # of children, and name of significant other:_____

Education

Highest grade completed:_____ Did you attend tech/trade school?_____

Area of Study?_____

Previous employment:_____

Reasons for leaving:_____

Military

Have you been in the armed forces?_____ If yes, when?_____

Branch:_____ Duty:_____

Rank:_____ Honorable discharge?_____

Legal

Have you ever been arrested?_____

If yes, please list all offensives, and result:_____

Do you have a pending case?_____ Are you seeking therapy for court?_____

Are you on probation/parole at this time?_____

If yes dates of term:_____

Recreation/Socialization

How would you describe your friendships?_____

Describe your daily activities:_____

_____

What activities do you enjoy?_____

_____

What recreational activities do you participate in?_____

_____

Financial

Do you currently have financial problems?_____

Please Explain:_____

Treatment History

Have you previously participated in therapy?_____

If yes. When and why?_____

_____

Do you actively attend any self-help groups?_____

If yes, name of group and frequency:_____

_____

Mental Health

Are you experiencing any of the following?

Depression ____
Anxiety _____
Frequent fears _____
Guilt ____
Poor sleep ____
Mood swings ____
Nervousness ____
Anger ____
Low self-worth _____
Hearing voices/noises in your head____
Panic____

Seeing things that you question____
Cutting____

Is someone trying to hurt you? ___

If yes, explain: _____

_____

Do you currently have thoughts of suicide? _____

If yes, what would you do?_____

Have you ever attempted suicide? _____

If yes, when and what did you do?_____

_____

Do you currently have thoughts of hurting someone? _____

If yes, who and how? _____

_____

Have you hurt someone in the past? ___

If yes, who and how?_____

_____

Substance Abuse

Do you drink alcohol?____

If yes, how much, type, and frequency? _____

What is your highest period of use?_____

Do you use drugs? ___

If yes, how much, type, and frequency? _____

What is your highest period of use: _____

Do you feel you have a substance abuse problem? Unsure? Explain your answer:_____

_____

Have you used any substances in the last 48 hours? ____

If yes, type and quantity: _____

Please list family members who you suspect or know have substance use problems and if they are still using:_____

Medical History

Current diagnosed health conditions:_____
_____

List medications are you currently taking and their doses:_____

_____

_____

List past medications: _____

_____

List hospitalizations:_____

_____

List past medical conditions or injuries:_____

_____

Significant family medical and psychological history:_____

_____

Parents of Children and Adolescents As you are painfully aware, mental health and substance abuse problems can be devastating when left untreated. We all know that when a problem is addressed early it is much easier to find solutions. We ask that you take a few additional moments to think about your children/child.

We know that certain situations put a child at a greater risk of developing mental health and/or substance abuse problems. The following “red flags” are provided to help you evaluate whether your child/children may be at risk. If within your household any or several of the following situations exist, please strongly consider requesting an evaluation for your child/children.

___ADD/ADHD/school problems/teacher concern

___child in mental health/substance use therapy
___custody
___problems/issues
___disabling illness in child/teen
___difficulty with divorce issues
___drug/alcohol abuse in a parent/guardian
___sexual/emotional/physical abuse/neglect
___periods of homelessness
___foster care/child care by other than relatives
___multiple family relocation
___jail/prison for a guardian or parent
___ Death of child/teen’s family member/friend
___latch-key issues
___Child/teen being bullied
___major financial problems
___teen/child abortion/pregnancy
___mental illness in a parent/guardian
___teen/child abusive relationships
___spousal/significant other abuse
___cutting behavior
___disabling physical/mental illness in guardian/parent

Patient’s signature/Parent/Legal guardian's signature

Date

Signature of therapist

Date

Signature of Supervisor Date

Full Circle Behavioral Health, PC.
West Bloomfield,

(248)722-2653

Contact Lori Little, MA, Psychotherapist to answer any questions, for a Free and confidential phone consultation, or to make an appointment at (248)722-2653 or Contact Us To return to Home Page