BODY-BASED PSYCHOTHERAPY OF METRO DETROIT, PLLC

NAME: ________________________________ DATE OF BIRTH: _______________________

PERSONAL HISTORY

(Confidential Information)

ADDRESS: ____
Street City State Zip

TELEPHONE: ____________________/__________________ OKAY TO CALL? Yes / No
Home Cell

EMERGENCY CONTACT PERSON: ____________________________________ RELATIONSHIP: ________________

EMERGENCY TELEPHONE: ___________________________________/_______________________________________
Home Cell

Why have you decided to enter treatment now? ____

____

What are your goals for treatment? ____

____

What is the source of distress in your life? ____

____

What are your main strengths and abilities? ____

____

What are your hobbies and special interests? ____

____

What are your weaknesses? ____

____

Do you spend leisure time (check all that apply): ___ Alone ___ with Family ___ with Friends/Peers

At times do you isolate yourself from others? Yes / No

EDUCATION

Highest grade completed: _______ Are you currently in school? Yes / No

If so, where? _____________________________ Major: ________________________________

Are you satisfied with your current level of education? Yes / No Please explain: ____________________

____

EMPLOYMENT

Are you employed: _____ Full-Time _____ Part-Time _____ Unemployed _____ Retired

Employer: ____

Are you satisfied with your current position? Yes / No Please explain: _____________________________

____

Are you experiencing any financial difficulties? Yes / No Please explain: ______________________________

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RESIDENTIAL SITUATION

Do you live with: _____ Parents _____Significant Other _____ Spouse _____ Alone _____ Other: ____________

SOCIAL INFORMATION

Religion: ___ Catholic ___ Protestant ___ Jewish ___ Hindu ___ Muslim ___ Other: ________________

Were you raised in a home that practiced the above religion? Yes / No

How important are your religious, spiritual, or faith-based beliefs? ____

MILITARY SERVICE

Have you ever served in the armed forces? Yes / No If so, which branch? ______________________________

Do you have combat experience? Yes / No

LEGAL HISTORY

Have you ever been arrested? Yes / No If so, please explain: ____________________________________

Are you currently facing any charges? Yes / No If so, please explain: ________________________________

Are you currently on probation or parole? Yes / No If so, what court and for what reason? ________________

____

FAMILY HISTORY

MARITAL STATUS: _____ Single ______ Married ______ Divorced ______ Separated ______ Widowed

IF MARRIED: 1st Marriage ____

Age Date # of Children If divorced, provide date

2nd Marriage ____

Age Date # of Children If divorced, provide date

How would you describe your relationship with your significant other? ______________________________________

____

What difficulties have you experienced in your present or past relationships? __________________________________

____

Have you ever experienced any violence in your relationships (sexual, physical, verbal, or emotional)? Yes / No
If so, please describe: ____

____

____

____

____

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FAMILY MEMBER	NAME	AGE	EDUCATIONAL LEVEL	DOES THIS PERSON LIVE WITH YOU?
Spouse/ Significant Other				
Children				
Mother				
Father				
Siblings/Others				

BIOLOGICAL PARENTS WERE: _____ Married ______ Unmarried ______ Separated ______ Divorced ______ Unknown

If parents were divorced, how old were you? _____ Describe how the divorce affected you: ________________________________

____

How would you describe your relationship with your extended family? ____

____

If adopted, when were you told? ____

Please indicate (circle) if there is a family history with any of the following:

Substance Abuse Yes / No If yes, who?____

Mental Illness Yes / No If yes, who?____

Depression Yes / No If yes, who?____

Anxiety Yes / No If yes, who?____

Suicide Yes / No If yes, who?____

Developmental
Disability Yes / No If yes, who?____

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Autism Yes / No If yes, who?____

ADHD Yes / No If yes, who?____

PHYSICAL/MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: ____

ADDRESS: ____

TELEPHONE/FAX: ____

Last visit to your physician: ____________________ Reason for last visit: ______________________________

Describe your current general health: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

Are you in any physical pain at this time? Yes / No If yes, please explain: ________________________________

____

Have you gained or lost weight in the last 30-60 days? Yes / No If yes, how much and why?____________________

____

Do you have any diet or nutritional concerns? Yes / No If yes, please explain: ____________________________

____

Have you ever binged (excessive or uncontrolled indulgence in food) or purged (self-induced vomiting, use of laxatives)? Yes / No
If yes, please indicate duration and frequency: ____

Do you have any illnesses or medical problems? Yes / No
If yes, please explain: ____

____

Medical/surgical hospitalization history: ____

____

CURRENT PRESCRIPTION MEDICATION, OVER-THE- COUNTER MEDICATIONS, HERBAL, AND NATURAL REMEDIES	**DOSAGE**	**FREQUENCY**	**REASON FOR USE**	**PHYSICIAN**

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Are you allergic to any medication(s)? Yes / No If so, which one(s)? ____

PLEASE CHECK SYMPTOMS THAT APPLY TO YOU

CONSTITUTIONAL SYMPTOMS

___Recent weight change

___Fever

___Fatigue

EARS/NOSE/MOUTH/THROAT

___Nose Bleeds

___Bleeding gums

___Swollen glands in neck

EYES

___Eye disease/injury

___Blurred or double vision

___Glaucoma

CARDIOVASCULAR

___ Chest pain or angina pectoris

___ Palpitations

___ Shortness of breath walking/lying flat

RESPIRATORY

___Chronic or frequent coughs

___Spitting up blood

___Asthma or wheezing

GASTROINTESTINAL

___Loss of appetite

MUSCULOSKELETAL

___Joint Pain

___Difficulty in walking

___Muscle pain or cramps

INTEGUMENTARY (SKIN)

___Varicose Veins

___Rash or itching

___Change in skin color

NEUROLOGICAL

___ Stroke

___ Convulsions or seizures

___ Frequent or recurring headaches

ALLERGIES/IMMUNE

___Itchy or runny nose

___Itchy or running eyes

___Food intolerances

ENDOCRINE

___Thyroid disease

___Glandular or hormone problem

___Diabetes

___Change in hat or glove size

___Heat or cold intolerance

NAME: ________________________________ DATE OF BIRTH: _______________________

___Nausea or vomiting

___ Painful bowel movements or constipation

___ Frequent diarrhea

___ Rectal bleeding or blood in stool

___Peptic ulcer

GENIOURINARY

___Frequent urination

___Blood in urine

___Kidney stones

___Incontinence or dribbling

HEMATOLOGIC/LYMPHATIC

___ Slow to heal after cuts

___Phlebitis

___ Past transfusion

___Bleeding or bruising tendency

___Anemia

TRANSMITTED DISEASE

___Hepatitis

___HIV

___Syphilis

Patient is responsible to follow up with their Primary Care Physician or Specialist for any above positives on this page.

SUBSTANCE USE AND HISTORY

SUBSTANCE	AGE OF ONSET	AGE AT REGULAR USE	AGE OF LAST USE	AMOUNT USED IN LAST 48 HOURS	AMOUNT USED IN LAST 30 DAYS	HAS AMOUNT USED INCREASED?
Alcohol						
Benzodiazepines (Xanax, Klonopin, Ativan, etc.)						
Cocaine/Crack						
Methamphetamines						
Opiates (Vicodin, Oxycontin, Heroin, etc.)						
Marijuana						
Hallucinogens (PCP, LSD, Mescaline, etc.)						
Inhalants						
Caffeine						
Energy Drinks						
Nicotine						
Other						

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BEHAVIORAL HEALTH

Are you now or have you ever thought of or attempted to hurt yourself? Yes / No If so, please explain: ___________________
____

Are you now or have you ever thought of or attempted to hurt someone else? Yes / No If so, please explain: ________________
____

Do you have access to firearms or other weapons? Yes / No If so, please describe: _________________________________

MENTAL HEALTH TREATMENT

TREATMENT PROVIDER	PERIOD OF TIME	INPATIENT OR OUTPATIENT	REASON	WHY DID YOU STOP?

PAST PSYCHIATRIC MEDICATION USED	DOSAGE	DATES OF USE	RESPONSE TO MEDICATION

Have you ever attended a support group (AA, NA, Grief, etc.)? Yes / No If yes, what group and for how long? ______________
____

Have you ever experienced any: ___ Physical Abuse ___ Sexual Abuse ___ Emotional Abuse ___ Abandonment/Neglect
If yes, by whom? ____
Length/duration of abuse: ____ Age of abuse: ____________________

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IAPT PHOBIA SCALES

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.

0	1	2	3	4	5	6	7	8
Would not avoid it		Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it

1.	Social situations due to fear of being embarrassed or making a fool of myself.	
2.	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness).	
3.	Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).	

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GAD-7	**Over the past 2 weeks how often have you been bothered by any of the following problems?**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Feeling nervous, anxious or on edge.	**0**	**1**	**2**	**3**
2.	Not able to stop or control worrying.	**0**	**1**	**2**	**3**
3.	Worrying too much about different things.	**0**	**1**	**2**	**3**
4.	Trouble relaxing.	**0**	**1**	**2**	**3**
5.	Being so restless that it is hard to sit still.	**0**	**1**	**2**	**3**
6.	Becoming easily annoyed or irritable.	**0**	**1**	**2**	**3**
7.	Feeling afraid as if something awful might happen.	**0**	**1**	**2**	**3**
For office use only	***GAD-7 total score =***				

PHQ-9	**Over the last 2 weeks how often have you been bothered by any of the following problems?**	**Not at all**	**Several days**	**More than half the days**	**Nearly day**
1.	Little interest or pleasure in doing things.	**0**	**1**	**2**	**3**
2.	Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3.	Trouble falling or staying asleep, or sleeping too much.	**0**	**1**	**2**	**3**

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4.	Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5.	Poor appetite or overeating.	**0**	**1**	**2**	**3**
6.	Feeling bad about yourself – or that you are a failure or have let yourself or family down.	**0**	**1**	**2**	**3**
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	**0**	**1**	**2**	**3**
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9.	Thoughts that you would be better off dead or of hurting yourself in some way.	**0**	**1**	**2**	**3**
For office use only	***PHQ-9 total score =***				

Please sign this document below. You will review with your therapist during your next visit.

____ _______________

Patient/Parent/Guardian Signature Date

____ _______________

Signature with Credentials Date