Therapy Information Form

Name:_____ Date:_____

What issues / problems are causing you to seek counseling?

_____
_____
_____
_____
_____
_____

How long have these been a concern? _____

How have these effected your life? (work, personal life, family, happiness, etc.)

_____
_____
_____
_____
_____

List the friends or family that live close by and briefly describe your relationship with them.

_____
_____
_____
_____
_____
_____
_____
_____

Describe your relationship with the person that you feel the closest to: _____

_____
_____
_____
_____

Are you dissatisfied with any part of this relationship? Yes_____ No _____

Comments: _____

_____

Education: _____

Occupation: _____

STEVE B. REED, L.P.C., L.M.S.W., L.M.F.T.
375 MUNICIPAL DR., SUITE 230, RICHARDSON, TEXAS 75080 (972) 997-9955
www.psychotherapy-center.com

Do you have any traumatic memories? Yes_____ No _____ If so, please list them and the age that you were when the event happened:

_____
_____
_____
_____
_____
_____

Are you able to remember your childhood? Yes _____ No _____

How would you describe your childhood?

_____
_____

Are there any specific blocks of time that you can not remember? Yes _____ No _____
Comments: _____

Do you have difficulty controlling your anger? Yes _____ No _____ Describe below:

_____

Do you experience any panic, anxiety, phobias or frequent worry? Yes _____ No _____
Describe: _____
_____

Are you feeling depressed? Yes _____ No _____ If yes, for how long? _____
Describe your history regarding depression: _____
_____
_____
_____

Do you find yourself repeating any actions compulsively? (even though you don't want to)
Yes _____ No _____ Describe:_____
_____

Do you have any obsessive thoughts that you just can't keep from thinking? Yes____ No____
Explain: _____
_____

List the things that have been the most stressful during the last two years: _____
_____
_____
_____
_____

STEVE B. REED, L.P.C., L.M.S.W., L.M.F.T.
375 MUNICIPAL DR., SUITE 230, RICHARDSON, TEXAS 75080 (972) 997-9955
www.psychotherapy-center.com

Have you experienced any unwanted weight gain, weight loss or loss of appetite recently?
Yes _____ No _____ Describe:_____

Do you smoke? Yes _____ No _____ How long?_____

Do you drink alcohol? Yes _____ No _____ Type? _____
How often? _____ How much? _____

Do you use illegal drugs? Yes _____ No _____ Frequency? _____

Do you have a history of drug or alcohol abuse? Yes _____ No _____ Explain: _____
_____

Do you take any prescription medications for psychiatric reasons? Yes _____ No _____
If so, list the Rx, the dosage and what it is for:_____
_____
_____

Do you have any medical problems that adversely effect your mind or emotions?
Yes _____ No _____ Explain: _____
_____

Are you in treatment with anyone else for psychotherapy, counseling, or psychiatry?
Yes _____ No _____ If so, please list by name and phone number:
_____
_____
_____

List the name and phone number of your primary care physician: _____
_____

List other relevant health care providers by name and phone number: _____
_____

I give Steve B. Reed, LPC, LMSW, LMFT permission to receive information from and provide information to any of my health care team in order to facilitate my treatment.

Print your name: _____

Your signature: _____ Date: _____

Please add any additional information that may be relevant to your treatment: _____
_____
_____
_____