

Windermere Counseling Corp.
104 W 6th Ave. Windermere, FL 34786
407-876-2078

History and Medical Information

Please print clearly and leaving nothing blank. Thank you.

Name _____ Date of Birth _____ Date _____

Briefly describe why you are here

Approximately how long has this been a problem for you? _____

Is this problem ___ mild ___ moderate ___ severe

Does this problem affect ___ work ___ relationships ___ health ___ other _____
 Have there been recent changes in ___ weight ___ appetite ___ sleep ___ health ___ other

Anxiety ___ mild ___ moderate ___ severe

Depression ___ mild ___ moderate ___ severe

Please name all those living in your home (start with yourself)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Description</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any children not living in your home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Description</u>
_____	_____	_____	_____
_____	_____	_____	_____

Concerns with present family _____

Marital Status:

___ Married ___ Never Married ___ Domestic Partnership ___ Separated ___ Divorced ___ Widowed

If in a relationship, how long? _____

On a scale of 1(great) -10(seriously in trouble-could end), how would you rate your relationship?

Sexual Orientation:

___ Heterosexual ___ Homosexual ___ Bisexual _____

Please use initials to identify problems or concerns for Self/Family:

- | | | | |
|-------------------|------------------------|----------------------|-------------------|
| ___ fears | ___ shyness | ___ loneliness | ___ relaxation |
| ___ panic attacks | ___ separation/divorce | ___ guilt | ___ legal issues |
| ___ friends | ___ anger | ___ nightmares | ___ crying spells |
| ___ unhappiness | ___ stress | ___ stomach/bowel | ___ concentration |
| ___ headaches | ___ tiredness | ___ stepfamily | ___ marriage |
| ___ memory | ___ ambition | ___ making decisions | ___ finances |
| ___ energy | ___ grief | ___ career choices | ___ sexual |
| ___ temper | ___ parenting | ___ low self-esteem | ___ drugs |
| ___ self-control | ___ certain thoughts | ___ suicidal | _____ |

Windermere Counseling Corp.
104 W 6th Ave. Windermere, FL 34786
407-876-2078

Name _____ Date _____

Please list any stressful life events that have occurred in your life span that remain somewhat distressing to you today when you think about it (feel free to write on the back if needed): _____

Is there any history of childhood abuse? ___ verbal ___ emotional ___ physical ___ sexual ages _____
 If yes, who was responsible for the abuse? _____
 Identify if there is a family history of any of the following: If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Alcohol Abuse	yes/no	_____
Substance Abuse	yes/no	_____
Depression	yes/no	_____
Addictive behaviors	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
PTSD	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide attempts	yes/no	_____
ADD	yes/no	_____
Legal Issues	yes/no	_____
Psychiatric Medications	yes/no	_____
Serious/Chronic Medical Conditions	yes/no	_____

Previous Mental Health Care:

Please describe any prior counseling you have had (include dates and name of therapist):

___ None ___ Yes, previous providers: _____

Psychiatric Medications:

Present and past prescribed psychiatric medications (including sleep aids, over the counter products, herbals)

<u>Name</u>	<u>By Whom (M.D.)</u>	<u>Dose</u>	<u>How long</u>	<u>Results</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Windermere Counseling Corp.
104 W 6th Ave. Windermere, FL 34786
407-876-2078

Alcohol, Drug use and Addictions:

Please list all recreational drugs you use **now** or **have used** or experimented with: (Please include alcohol and nicotine)

<u>Drug name</u>	<u>When (ages)</u>	<u>How long (how many times)</u>	<u>Amount/Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone expressed a concern to you about your use of alcohol or other substances? ___ Yes ___ No

Do you have any concerns about addictive tendencies? ___ Yes ___ No circle those that apply:

Gambling Sex Internet TV Hoarding Spending money Thrifting
 Food Debting eading Exercising Alcohol Drugs

Other: _____

Physical Wellbeing:

Who is your Primary Care Physician? _____ Phone _____

How would you rate your current physical health? (please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (please circle): How many hours a night, on average ___

Poor Unsatisfactory Satisfactory good very good

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns. _____

Please list any known medical conditions you have and medications (including herbal remedies) you are taking for them:

<u>Medical concern</u>	<u>Medication</u>	<u>Dosage</u>	<u># per day</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

What methods do you use to calm down or soothe yourself when stressed? _____

Education and Employment

Education: Please describe your education history : High School Some College

Degree _____

What is your current employment situation? _____

Do you enjoy your work? ___ Yes ___ No

Windermere Counseling Corp.
104 W 6th Ave. Windermere, FL 34786
407-876-2078

Is there anything stressful about your current work? _____

Spirituality

Do you consider yourself to be spiritual or religious? ____ Yes ____ No

If yes, describe your faith or belief:

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____

Goals for therapy

What goals would you like to accomplish in counseling?

1.) _____

2.) _____

3.) _____

Signature

8/11 10/12

date