

HYGEIA COUNSELING SERVICESSM

a d u l t p s y c h o t h e r a p y



Proper treatment requires as much historical information as possible. Please fill this out to the best of your abilities. Completing this outside of session will maximize our therapy time. We will likely go over some of the answers. Please feel free to ask questions or to write "I decline" for information you would rather not reveal.

Name: _____ Date of Birth: _____

Psychiatric History

Prior Counselor/Psychiatrist _____		Prior Counselor/Psychiatrist _____
Dates of Treatment _____		Dates of Treatment _____
Treated for: _____		Treated for: _____
Type of Treatment (circle one) outpatient inpatient group medication other _____		Type of Treatment (circle one) outpatient inpatient group medication other _____

Please continue psychiatric history on back of page as needed.

Has anyone in your family ever been diagnosed with or thought to have symptoms of any mental disorder? If so, whom and what illness? Any suicide attempts by family members?

Psychosocial History

Marital Status (circle one): married domestic-partner divorced separated single
Children's names & ages (if any): _____
Please list people who are emotionally supportive of you: _____
Do you have a history of interaction with the law? If so, what: _____
Highest degree you have achieved (circle one): high-school 2-yr-college 4-yr-college masters doctorate other
What are your hobbies, interests, & daily activities?: _____
Name & age of parents (if deceased, cause & age at death): _____
Nature of relationship with parents (past & current): _____
Sibling's names & ages (if any): _____

Work History

Please list last four job titles & dates held:

What are your career goals?

How satisfied are you with current job?

WASHINGTON & BALTIMORE LOCATIONS

Voicemail & Fax: 877-823-3439 : <http://www.hygeiacounseling.com> : michael@hygeiacounseling.com

Mailing Address: 10482 Baltimore Ave #193, Beltsville, MD 20705

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Medication/Drug History

Names, dosage, & notable side effects of current medication:

Past psychiatric medications (including ADHD, sleep, & anti-depressants from somatic physician):

Frequency and quantity of caffeinated beverages, nicotine products, alcohol, illegal drugs, and marijuana:

Special Factors

Are you currently suicidal or homicidal? _____

Do you have a history of either one? _____

Are you court-ordered or otherwise required to receive treatment? _____

Do you have a history of self-mutilation such as cutting or burning yourself? _____

Have you ever been diagnosed with, or thought to have, anorexia or bulimia? _____

Do you have weapons in your home? _____

Have you ever been abused? (circle one) no sexual rape physical domestic-violence What age? _____

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