History Form

Privacy Statement: Any information provided on this form is subject to the strictest confidentiality. No information will be shared with others. All submissions will be responded to within one business day.

Last Name

First Name

Middle Initial

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed

Enter your Time Zone

Birth Date

Age

Gender

- Male
- Female

Occupation

Employer

Street Address

P.O. Box

City State

Country/Province

Postal Code

Home Phone #

Other Phone #

Skype Username

Can we leave a message on your home phone?

- Yes
- No

Can we leave a message on other phone?

- Yes
- No

Email Address:

What service(s) is requested at this time? Counseling or Therapy:

- ☐ Counseling
- ☐ Therapy

What concern has prompted you to contact me at this time?

Please check the box in front of any word or phrase you feel applies to you:

- ☐ Headaches
- ☐ Heart palpitations
- ☐ Sleep problems
- ☐ Want to hurt self
- ☐ Want to hurt others
- ☐ Hyperactive
- ☐ Diabetes
- ☐ Hysterectomy
- ☐ Drug use
- ☐ Financial problems
- ☐ Incompetent
- ☐ Tend to be Controlling
- ☐ Shy
- ☐ Don't take vacations
- ☐ Confused
- ☐ Considerate
- ☐ Handicapped
- ☐ Not confident
- ☐ Can't make decisions
- ☐ Can't make friends
- ☐ Stomach problems
- ☐ Feelings of panic
- ☐ Trembling
- ☐ Unable to relax
- ☐ Nervous
- ☐ Fearful
- ☐ Timid
- ☐ Visual hallucinations
- ☐ Auditory hallucinations
- ☐ Inattentive
- ☐ Hypoglycemia
- ☐ Hormonal problems
- ☐ Can't concentrate
- ☐ Worthwhile
- ☐ Regrets from past
- ☐ Misunderstood
- ☐ Sympathetic
- ☐ Fairly intelligent
- ☐ Fainting spells
- ☐ No appetite
- ☐ Regular alcohol use
- ☐ Depressed
- ☐ Inadequate
- ☐ Disturbing thoughts
- ☐ Guilty
- ☐ Hateful
- ☐ Feel Inferior
- ☐ Bad home conditions
- ☐ Memory problem
- ☐ Unattractive
- ☐ Bored
- ☐ Restless
- ☐ Delusions
- ☐ Thyroid problems
- ☐ Menopause
- ☐ Can't keep a job
- ☐ Nightmares
- ☐ Empty feelings
- ☐ Fatigue
- ☐ Tense feeling
- ☐ Sex problems
- ☐ Worthless
- ☐ Stupid
- ☐ Evil
- ☐ Over ambitious
- ☐ Good person
- ☐ Dizziness
- ☐ Attractive
- ☐ Lonely
- ☐ Not loved
- ☐ Confident

Who should be contacted in case of emergency?

Relationship to patient

Home Phone #

Work Phone #

Have you ever been in treatment with a therapist or counselor in the past?

- ○ Yes
- ○ No

If so, when were you treated and for what problem(s)?

What was the result of this treatment?

Are you being treated by a therapist, counselor, or psychiatrist now?
- ○ Yes
- ○ No

Are you experiencing any negative feelings or "symptoms" at this time, e.g. feeling anxious, depressed, sad, angry, frustrated, etc?
- ○ Yes
- ○ No

How severe would you say your symptoms are?
- ○ Mild
- ○ Moderate
- ○ Severe

Is there anything you would like to tell me about your current treatment?

What have you already tried for this problem?

Have you tried anything that DOES help?
- ○ Yes
- ○ No

If "Yes", what DID help?

Are you currently taking any psychotropic medication (e.g., anti-depressants or anti-anxiety medication)?
- ○ Yes
- ○ No

If so, what type of doctor prescribed it?

- Physician
- Psychiatrist
- Other

Have you taken any psychotropic medication in the past?

- Yes
- No

Please list all medications you are now taking, including the dosage. Please include prescriptions, over-the-counter, herbal, homeopathic medications and nutritional supplements.

How often do you drink alcohol?

- Never
- Rarely
- Occasionally
- Frequently
- Heavily

Do you use recreational drugs?

- Never
- Rarely
- Occasionally
- Frequently
- Heavily

Please list below all recreational drugs you use.

Have you ever been hospitalized for drug or alcohol abuse, a suicide attempt, "nerves" or other mental health Concern?

- Yes
- No

If "Yes", please give dates and circumstances:

If you are married or have a "significant other" or long-term partner, how long have you been together?

Please describe your relationship:

If you have any children, please list their names and ages:

Name:		Age:	
Name:		Age:	
Name:		Age:	
Name:		Age:	

Who lives in the household with you?:

Name:		Relationship:	
Name:		Relationship:	
Name:		Relationship:	
Name:		Relationship:	

Do you have any brothers or sisters?

- ○ Yes
- ○ No

If so, where are you in the sibling order?

- ○ Oldest
- ○ Middle
- ○ Youngest

Where do your siblings live and how do you get along with them?

Are your parents alive?

- ○ Yes
- ○ No

How do you get along with them?

Do you have in-laws?

- ○ Yes
- ○ No

How do you get along with them?

How much education have you completed?

- ☐ Some High School
- ☐ High School Diploma
- ☐ GED
- ☐ Some College
- ☐ College Diploma

If you are a student now, please complete the following 2 questions:

Which school do you attend, how are your grades and how do you like school?

If you are in college or graduate school, what is your major?

Are you happy with your current job/career?

- ○ Yes
- ○ No

If not, why?

What jobs/careers have you had in the past and did you like them?

How many times have you moved in the past year?

- ○ None
- ○ 1 Time
- ○ 2 Times
- ○ 3 Times
- ○ 4 Times
- ○ 5+ Times

How is your overall health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

If you have any medical problems now or in the past that would be helpful for me to know about, please describe:

Have you ever been arrested or convicted of a crime? ○ Yes ○ No

If "Yes", please explain:

It would be helpful to know about your family of origin, what your childhood was like, and anything else about what your family and life were like when you were growing up. (If your past history includes abuse of any type, please include this.)

Were you ever physically or sexually abused as a child?

If so, by whom?

Are you being physically or sexually abused now? ○ Yes ○ No

If so, by whom?

Have you ever felt in the past like harming yourself or somebody else? ○ Yes ○ No

Do you have those feelings now? ○ Yes ○ No

Is there anything else about you that I should know?

I have read and agree with DistanceTherapy's Informed Consent. ☐

Thank You!