

GRACE COUNSELING GROUP

4132 Katella Ave, Suite 104

Los Alamitos, CA 90720

**Personal Data and Medical History**

Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Personal Information:**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Init.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female;  Single  Divorced  Married

Spouse's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Contact Information** (check box if it's okay to leave a message):

Home Phone: \_\_\_\_\_  Message Cell Phone 1: \_\_\_\_\_  Message  Text

Work Phone: \_\_\_\_\_  Message Cell Phone 2: \_\_\_\_\_  Message  Text

Email: \_\_\_\_\_ Email: \_\_\_\_\_

**Work Information:**

Company: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Medical Insurance Data:**

Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Highest Level Education:**

Middle School  High School / GED  Jr College  4 Yr College  Graduate  Doctorate

**Presenting Problems / Issues:**

In your own words, please describe the nature of the problem that brings you to therapy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to accomplish through therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please rate the seriousness of these issues on a scale of 0 (not at all) to 10 (Extremely serious): \_\_\_\_\_

## Medical History

Last physical exam: \_\_\_\_\_ Name of Physician: \_\_\_\_\_

Height: \_\_\_\_\_, Weight: \_\_\_\_\_ lbs, Weight 1 yr ago: \_\_\_\_\_ lbs, Maximum: \_\_\_\_\_ lbs, Date: \_\_\_\_\_

Exercise: Frequency: \_\_\_\_\_/week. Strenuousness (0 - not at all, 10 – Extremely): \_\_\_\_\_.

Type/s : \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

Sleep:  Well,  Restless,  Fitful,  Difficulty going to sleep,  Difficulty staying asleep,

Rested in the morning,  Morning person,  Evening person

Number of times up during night: \_\_\_\_\_ Number of hours of sleep per night: \_\_\_\_\_

Eating: Number of meals per day \_\_\_\_\_ Diet:  Healthy / Balanced,  Special diet,  Poor food,

What do you do for recreation: \_\_\_\_\_ How often? \_\_\_\_\_

What time in your life was the most difficult time during your mental and physical development?  Present

Infancy  Toddler  Preschool  Elementary  Jr. High  High School  College  Adult

### How often do you have problems with:

	<u>Never</u>	<u>Seldom</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Insomnia	<input type="checkbox"/>				
Sleep Apnea	<input type="checkbox"/>				
Back Pain	<input type="checkbox"/>				
Body Pain	<input type="checkbox"/>				
Headaches	<input type="checkbox"/>				
Fatigue	<input type="checkbox"/>				
High Blood Pressure	<input type="checkbox"/>				
Vertigo / Dizziness	<input type="checkbox"/>				
Ringing in Ears	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>				
Asthma	<input type="checkbox"/>				
Lung Problems	<input type="checkbox"/>				
Nausea	<input type="checkbox"/>				
Constipation	<input type="checkbox"/>				
Diarrhea	<input type="checkbox"/>				
Over-eating	<input type="checkbox"/>				
Attention Span	<input type="checkbox"/>				
Poor Concentration	<input type="checkbox"/>				
Memory Loss	<input type="checkbox"/>				
Writing	<input type="checkbox"/>				
Talking	<input type="checkbox"/>				
Physical Handicap	<input type="checkbox"/>				

If any of the above are checked for sometimes or more, please describe the problem:

---



---



---



---

## Medication / Treatment History

How often do you use:	<u>Never</u>	<u>Seldom</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Caffeine (Coffee, Soda, Tea)	<input type="checkbox"/>				
Energy Drinks	<input type="checkbox"/>				
Tobacco	<input type="checkbox"/>				
Alcohol	<input type="checkbox"/>				
Aspirin / Tylenol / Aleve	<input type="checkbox"/>				
Appetite Suppressant	<input type="checkbox"/>				
Sleeping Pills (Rx **/ OTC *)	<input type="checkbox"/>				
Insulin	<input type="checkbox"/>				
Blood Pressure Meds	<input type="checkbox"/>				
Heart Medications	<input type="checkbox"/>				
Sinus Medications	<input type="checkbox"/>				
Pain Medications (Rx **)	<input type="checkbox"/>				
Sedatives / Tranquilizers	<input type="checkbox"/>				
Vitamins	<input type="checkbox"/>				
OTC Herbal *	<input type="checkbox"/>				
OTC Supplemental *	<input type="checkbox"/>				
OTC Medications *	<input type="checkbox"/>				

\* OTC – Over the counter, \*\* Rx – prescribed medication

If using Tobacco or Drugs, describe each type, amount, and frequency: \_\_\_\_\_

If using alcohol, describe type, amount and frequency: \_\_\_\_\_

Have you ever misused or abuse the use of prescription or non-prescription medications, describe: \_\_\_\_\_

Please list current medications being taken:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Purpose</u>	<u>Physician's Name</u>
_____	_____mg	_____x day	_____	_____
_____	_____mg	_____x day	_____	_____
_____	_____mg	_____x day	_____	_____
_____	_____mg	_____x day	_____	_____
_____	_____mg	_____x day	_____	_____

Have you ever been Hospitalized:  Yes  No - If yes describe (include psychiatric):

Date: _____	Hospital: _____	Reason: _____	Length: _____
Date: _____	Hospital: _____	Reason: _____	Length: _____
Date: _____	Hospital: _____	Reason: _____	Length: _____
Date: _____	Hospital: _____	Reason: _____	Length: _____

## Psychological / Psychiatric History

Have you ever seen a counselor, therapist, psychologist or psychiatrist?  Yes  No

<u>Problem / Issue</u>	<u>Length</u>	<u>Date (mm/yyyy)</u>	<u>Successful</u>	<u>Name of Person doing Treatment</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**How often do you experience:** Never                      Seldom                      Sometimes                      Often                      Always

Substance use / abused:

Marijuana	<input type="checkbox"/>				
Narcotics	<input type="checkbox"/>				
Barbituates	<input type="checkbox"/>				
Meth / Amphetamines	<input type="checkbox"/>				
Cocaine	<input type="checkbox"/>				
Opiates	<input type="checkbox"/>				
Ecstasy	<input type="checkbox"/>				

Psychological Symptoms:

Substance Abuse	<input type="checkbox"/>				
Phobias	<input type="checkbox"/>				
Fears, Irrational	<input type="checkbox"/>				
Paranoia	<input type="checkbox"/>				
Anger / Easily Irritated	<input type="checkbox"/>				
Frustration	<input type="checkbox"/>				
Anxiety	<input type="checkbox"/>				
Nervousness	<input type="checkbox"/>				
Depression	<input type="checkbox"/>				
Impulsiveness	<input type="checkbox"/>				
Loss of Control	<input type="checkbox"/>				
Mood Swings	<input type="checkbox"/>				
Self-harm / Cutting	<input type="checkbox"/>				
Evil thoughts	<input type="checkbox"/>				
Audible Hallucinations	<input type="checkbox"/>				
Visual Hallucinations	<input type="checkbox"/>				
Delusions	<input type="checkbox"/>				
Amnesia	<input type="checkbox"/>				
Loss of time	<input type="checkbox"/>				
Binging / Purging	<input type="checkbox"/>				
Short Term Memory	<input type="checkbox"/>				
Long Term Memory	<input type="checkbox"/>				
Self-Esteem / Worth	<input type="checkbox"/>				
Confidence	<input type="checkbox"/>				
Assertiveness	<input type="checkbox"/>				
Obsessive / Compulsive	<input type="checkbox"/>				

Social / Relational Problems with:

Partner	<input type="checkbox"/>				
Family	<input type="checkbox"/>				
Children	<input type="checkbox"/>				
Authority	<input type="checkbox"/>				
Friends	<input type="checkbox"/>				

Do you have any emotional or psychological support from:  Partner  Family  Friends  Social Group/s

Have you ever attempted suicide - Number of times: \_\_\_\_\_ Date/s: \_\_\_\_\_ Current thoughts:  Yes