Tom Kelley, MA, LMFT
Licensed Marriage and Family Therapist
Individual, Couples and Family Therapy
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Please provide the following information to the best of your ability. This information will help me have some useful background information from which to draw from if necessary. Please fill out and bring to your first meeting. If you are unable to complete this form before arriving, please come a little early so we don't lose what time we have in session.

Client's Name:____
(Last) (First) (Middle Initial)

Date of Birth: ____________________________

Insured's name (if different) ______________________________ Date of Birth ___________________________

Spouse/Partner's Name (if applicable): ____

Children's names and ages: ____

Other people in the home? Name and ages: ____

Home Address: ____

____

Primary Phone: _______________________________ May I leave a message? _____________________

Contact E-mail: _______________________________ May I email you? _____________________

*Please be aware that e-mail may not be confidential

How did you find out about my services? ____

Are you currently receiving psychiatric services, or counseling elsewhere? yes____ no____

If yes, where? ____

Have you had previous psychiatric services, counseling or therapy? yes___ no_____

If yes, please provide previous therapist's name: _____________________________________

Are you currently taking any prescribed psychiatric medications (i.e. antidepressants?) yes___ no_____

If yes, please list current medications and dosage: ___________________________________

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If no, have you been previously prescribed psychiatric medications? yes___ no____

If yes, please list: ____

HEALTH AND SOCIAL INFORMATION

How would you describe your current physical health?

Poor______Unsatisfactory______ Satisfactory______ Good______ Very Good______

Please list any persistent physical symptoms or health concerns (i.e. chronic pain, headaches, hypertension, asthma, diabetes, vision or hearing problems). ______________________________

____

Are you having difficulties sleeping? yes___ no___

If yes:

Sleeping too little___ Sleeping too much______ Poor sleep quality______

Difficulty falling or staying asleep____Waking up too early_____Nightmares or distressing dreams______

Other ________________________________

How many times per week do you exercise? ____

What type of exercise do you do? ____

Any changes/problems with appetite or eating habits? yes___ no___

If yes:

Eating less______ Eating more______ Binging______ Restricting______

Have you experienced significant weight change in the last few months? yes___ no___

Have you ever used drugs or alcohol? yes___ no___

If yes, please describe:

Substance_________ Amount_______ Frequency (i.e. daily, weekly)_______ Last Use:___________________

Have you ever experienced any of the following? (Please check all that apply)

Extreme depressed mood ____________ Wild Mood Swings ___________ Rapid Speech _______________

Racing Thoughts _______ Hallucinations (auditory, visual, tactile) _______ Delusions _________________

Sleep Disturbances ________ Frequent Body Complaints ____

Repetitive Thoughts (i.e. Obsessions) _________ Repetitive Behaviors (i.e. hand washing) ________________

Suicidal Thoughts/Thoughts of Self-Harm __________ Homicidal Thoughts __________________________

Please indicate which of the following issues/problems you would like to address in therapy:

Depression______ Lack of friends______Anxiety/Panic______ Attacks Grief/Loss_______________________

Mood Swings______ Problems at School______Phobias______ Problems at Work _____________________

Sleep Disturbance______ Family Conflict______Stress______ Alcohol/Substance Abuse_________________

Traumatic Event______ Victim of Abuse (physical or sexual)______Other: _____________________________

FAMILY MEDICAL/PSYCHIATRIC INFORMATION

Has anyone in your family had a serious medical condition? yes___ no____

If yes, please explain: ____

Has anyone in your family (immediate or close relatives) experienced difficulties with the following?

Please check all that apply and list family member (i.e. sibling, parent, maternal aunt):

Difficulty		Family Member
Depression	yes___ no___	____
Bipolar Disorder	yes___ no___	____
Anxiety Disorders	yes___ no___	____
Panic Attacks	yes___ no___	____
Schizophrenia	yes___ no___	____
Alcohol/Substance Abuse	yes___ no___	____
Eating Disorders	yes___ no___	____
Learning Disabilities	yes___ no___	____
ADHD	yes___ no___	____
Trauma History	yes___ no____	____
Suicide Attempts	yes___ no___	____

OCCUPATIONAL /SCHOOL INFORMATION

Are you currently a student? yes___ no___

If yes, school's name and current grade: ____

Are you currently employed? yes___ no____

If yes, what is your current position? ____

Please list any school/work-related stressors: ____

If there is anything else that you would like me to know about, please include below:

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Thank you for your time,

Tom