



HEATHER WILLIAMS, MFT

MARRIAGE & FAMILY THERAPY

License # MFC41155

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PATIENT RECORD page 1 of 2

Patient: _____ DOB: _____ Current age: _____

Address: _____ City: _____ Zip: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Gender: Male ___ Female ___ Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Emergency Contact: _____ Telephone: (____) _____

Employer / School _____

Job Title / Grade _____

Relevant medical conditions (history, current condition, changes in condition)

Medications (dosage, length of time, prescribing clinician)

Allergies / Adverse reactions to treatment

Reason for seeking therapy: _____

Treatment goals: _____

Previous psychological or psychiatric treatment: _____

Psychiatric hospitalizations (dates and locations)

Family history of psychological or psychiatric treatment: _____

Alcohol use: Y / N (# _____ drinks weekly) Date last drank _____

Illegal drug use: (past or present) Y / N Date last used: _____ Type: _____

Family history of alcohol or drug use: _____

INDIVIDUAL, COUPLES AND FAMILY THERAPY



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PATIENT RECORD page 2 of 2

Police / Probation involvement (past or present) Y / N Date: _____ Please explain _____

Family Structure (please list others who live in your home / relationship / ages)

Please circle any applicable experiences (past or present)

Domestic Violence	Traumas	Sexual Abuse	Physical Abuse
Sleep Problems	Eating Disorders	Losses	Learning Problems
Suicide Attempts	Suicidal Ideation	Cutting/ Self Harm	Visual Hallucinations
Spending Sprees	Anger Outbursts	Lying	Phobias
Mood Changes	Worry/ Fear	Panic Attacks	Poor Concentration
Tearfulness	Fatigue	Hopelessness	Racing Thoughts

What are your strengths? _____

Weaknesses? _____

Motivation for treatment: _____

Other significant information: _____

Patient's Signature _____ Date _____

Therapist's Signature _____ Date _____