HEATHER WILLIAMS, LMFT
LICENSED MARRIAGE & FAMILY THERAPIST

PATIENT RECORD

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:_____

PATIENT RECORD

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 _____