Susan M Tinsley, LMFT

Personal and Family Record

To make our first meeting as productive as possible, please give accurate and complete responses to every section of this form.

Date________________________________

Last Name _____________________________________ First Name ______________________________
Address ____ City ____________________ Zip _________
Home Phone ____________________________ Cell Phone _____________________________________
Email ____

For appointment reminders, may I contact you by phone/text/email? Yes No

Birth Date ____

Employed by _______________________________ How long ____________ Position _______________
Referred by ____

Marital Status:

Single, never married ______ Engaged ______ Living together without marriage _______

Separated____ How long ____ Divorced ___ How long_____ Widower_____How long_____

Married _____ Spouse name _____________________ Age __________ Occupation ______________

How long married to this spouse? _________ Are you happy in this marriage?___________

Total prior marriages for you _______________ For your spouse _____________________

Children	Age	Sex	Relationship to you	Live in your house
____________________	____	____	___________________	______________________
____________________	____	____	___________________	______________________
____________________	____	____	___________________	______________________
____________________	____	____	___________________	______________________
____________________	____	____	___________________	______________________

COUNSELING

Have you ever been to counseling for any reason? Yes __________ No ____________

What reason _____________________________________ How long ________ Counselor ____________

Briefly state the nature of the current problem as you see it:

____

____

What do you want to gain from counseling:

____

____

What is your religious background, if any ____

MEDICAL INFORMATION

Describe your physical health: Excellent _____ Good _____ Adequate _____ Poor _____

Are you taking any prescription medications? Yes ______ No _______ If yes, state the

medication name and purpose ____

Have you taken prescription medication in the past? Yes ______ No ______ If yes, state

the medication name and purpose____

Have you ever been hospitalized for mental illness or substance abuse? Yes ___ No __

If yes, for what reason __________________________ How long were you in treatment ______

How long ago ______________ Did you continue with outpatient counseling? Yes___ No____

IMPACT OF LIFE CIRCUMSTANCES

Circle any LOSSES that you have experienced:

Death of: Spouse Child Father Mother Sister Brother Friend Divorce Separation Broken engagement Suicide Miscarriage Abortion Infertility Bankruptcy Homelessness Career of Job Loss Other ___________

Circle any VICTIMIZATIONS you have been involved with:

Child Abuse: Physical Emotional Sexual Incest Spouse Abuse: Physical Emotional Sexual Abandonment Rape Robbery Assault Suicide attempt Auto accident Major illness Surgery Physical disability Alienation Other _______________

Circle any ISSUES that concern you now: Relationships with:

Spouse Children Parents In-laws Co-workers Friends Alcohol Drugs Binge Eating Excessive dieting Cutting Shopping Work too much Procrastination Communication Depression Anger Grief Gender identity Sex Career Loneliness Mood swings Self-esteem Codependency Stress Fear Anxiety Finances Feelings about God or church Other ________________

CURRENT SITUATION	EXPLANATION
Suicidal thoughts, plans or attempts	____
Homicidal thoughts, plans, or attempts	____
Desire to cause pain to self	____
In fear for your life or personal safety	____
Too depressed to care for self or family	____

In signing below, I affirm that the information given on this form is true.

_______________________________ _______________

Client Date