Megan F. Gerbracht, Psy.D., LLC

INFORMATION FORM

EXCEPT IN CASES OF CHILD ABUSE OR IMMEDIATE DANGER TO YOURSELF OR OTHERS, ALL INFORMATION YOU PROVIDE WILL BE KEPT STRICTLY CONFIDENTIAL AND RELEASED ONLY IN ACCORDANCE WITH PROFESSIONAL ETHICS AND APPLICABLE LAW.

PERSONAL INFORMATION

NAME: _____ DATE:_____

ADDRESS:_____

PHONE (HOME):_____ (WORK):_____ AGE:_____

ETHNIC BACKROUND:_____ RELIGION:_____

HIGHEST GRADE OF EDUCATION:_____

PRESENT MARITAL STATUS: ____Single ____ Living together ____ Engaged

____ Married ____ Separated ____ Divorced ____ Remarried ____ Widowed

SPOUSE/PARTNER'S NAME:_____

SPOUSE/PARTNER'S RELIGION:_____

SPOUSE'S HIGHEST GRADE OF EDUCATION:_____

Number of years married/living together:_____

Were there any previous marriages for either spouse:_____ How many?_____

Husband:_____ Duration of each:_____ Wife: _____ Duration of each :_____

WHO IS LIVING IN YOUR RESIDENCE?

Name:	Age:	Relationship:

CHILDREN NOT LIVING AT HOME:

Name:	**Age:**

MEDICAL HISTORY

FAMILY Physician's Name:_____ Phone:_____

Do you or anyone else in your family have known medical problems, either current or past? If yes, please describe:_____
_____
_____
_____
_____

Are there any health related issues you think your therapist should know about?
_____
_____
_____

Are you or anyone in the family currently taking any medications? ____If yes, please list,
Medication(s):_____
Dosage(s):_____
Medicating Physician or Psychiatrist:_____ Phone:_____

FAMILY HISTORY:

Have there been any deaths in the immediate family? Please list by name and relationship and identify when these occurred.
_____
_____
_____
_____

Has anyone in your family or your partner's family ever attempted suicide? If yes, please explain._____
_____
_____

Has anyone in your family ever expressed concern about another family member's use of alcohol or drugs? Please Explain. _____
_____
_____
_____

Do you regularly: (if so, how much or how often?)
Drink:_____ Smoke:_____
Use prescribed or non-prescribed drugs?_____

If you do, does your habit hurt your relationships with others?_____

Does it hurt your job?_____

Is it difficult to stop or control the amount you take?_____

Has anyone ever expressed concern about the ways in which anger is managed in your family? If yes, please explain or give example (s).

_____
_____

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, punching. If yes, please explain:

_____
_____
_____
_____

Is there any history of violence, verbal or sexual Abuse in your family?_____

WHY YOU'RE HERE:

Please describe briefly the most important problems for which you would like help:

_____
_____
_____
_____

On a scale of 1 (mild) to 5 (severe), how would you rate your current problem? _____

How long has this been a problem?_____

How have you tried to correct this problem in the past?_____
_____
_____

Has anything changed since you made the decision to seek help?_____
If yes, what?_____

Have you considered counseling or therapy in the past?_____
If yes: Therapist? Reason for treatment? When was this? Was it helpful?

_____
_____
_____

In case of an emergency whom can we notify?
Name:_____ Relationship:_____
Phone: (Home)_____ (Work) _____

THANK YOU!