Legacy Psychological Services, LLC

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Phone (513) 522-0777, Fax (513) 522-4577

Name: DOB:

Please take a few moments to complete this background information. Please be as complete as possible.

CURRENT SITUATION

What concern brings you here? How long has this been a problem? What have you done or are you doing to resolve this problem?

What do you hope to accomplish today or in therapy?

How will you know things are better?

MENTAL HEALTH

Have you had mental health services, counseling, or alcohol/drug treatment? ☐ Yes ☐ No

If yes, please list names and dates below.

Outpatient therapist or program & date(s):

Inpatient hospital & date(s):

Regarding past treatment, what did you find most helpful, particularly effective, or not helpful at all?

What are your strengths? What do you have going for you?

FAMILY HISTORY

Living status: Single Married Widowed Divorced Partnered

Who lives with you?

Names & ages of children

Your marriages To Date

To Date

Please list any concerns you may have about family members.

Is there any history of emotional or mental problems in the family? ☐ Yes ☐ No

If yes, please explain:

Has anyone in your family had problems with alcohol or other drug use? ☐ Yes ☐ No

FAMILY OF CHILDHOOD

List names and current ages of parents:

and brothers & sisters:

Have you ever experienced: ☐ physical abuse ☐ sexual abuse ☐ emotional abuse

☐ rape/sexual assault ☐ poverty ☐ domestic violence ☐ other significant trauma

Please specify:

What was it like growing up in your home?

HEALTH HISTORY

Primary care physician Phone

Address

Do you have any physical impairments or limitations which may require special accommodations, special arrangements, or may affect your treatment, i.e., reading difficulties, hearing loss, vision loss, speech impairment? ☐ Yes ☐ No

Do you have any physical health problems? ☐ Yes ☐ No

If yes, what conditions?

Do you use tobacco products? ☐ Yes ☐ No Packs per day Other

Please describe the nutritional value/balance of your diet? ☐ great ☐ good ☐ fair ☐ poor

Are you having any eating problems as overeating, binge eating, loss of appetite, weight loss or weight gain? ☐ Yes ☐ No

Please specify:

How often do you exercise? ☐ never ☐ daily ☐ 2-3 times/week Other

How many hours of sleep do you get per 24 hr period? Comments

Are you having any problems with your sexual functioning? ☐ Yes ☐ No

Specify:

Do you have any drug/food allergies? ☐ Yes ☐ No

Specify:

Are you currently on any physician-prescribed or over-the-counter medication including prescriptions for anxiety, depression, or other mental condition? ☐ Yes ☐ No

If yes, list all medications or provide a current list at your first appointment.

Medication/purpose	Dosage/times per day	How long?	Taken consistently?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

In the past, have you taken medications for a mental health condition? Yes No

If yes, please describe:

ACTIVITIES OF DAILY LIVING

Please check areas that give you difficulty or require assistance from another person.

☐ grooming/hygiene ☐ shopping ☐ mobility ☐ leisure skills ☐ homemaking
☐ time management ☐ bathing ☐ childcare ☐ banking ☐ communication
☐ stress management ☐ cooking ☐ budgeting ☐ dressing ☐ transportation
☐ other:

Describe recent difficulties

ALCOHOL AND DRUG

Have you ever made a decision to cut back or quit using alcohol or other drugs? ☐ Yes ☐ No

Has anyone ever been annoyed about your use of alcohol, prescription medications or other drugs?
☐ Yes ☐ No

Have you ever felt guilty about your use of alcohol, prescription medication or other drugs?
☐ Yes ☐ No

Have you ever experienced any of the following in connection with your use of alcohol, prescription medications or other drugs? Check any that apply.

☐ financial problems ☐ relationship problems ☐ work problems ☐blackouts ☐ cravings
☐ increased tolerance ☐ physical problems ☐ emotional problems ☐withdrawal symptoms

CULTURAL/ETHNIC

Race/ethnic group:

Ethnic/racial issues that may require consideration:

Sexual orientation issues that may require consideration:

SPIRITUAL/RELIGIOUS

Active membership in organized religious group(s):

How does your religion/spirituality affect your daily life?

Religious/spiritual issues you'd like to talk about:

EDUCATION

Highest grade completed   Did you graduate from high school/GED?   Yes   No

Did you attend college or technical school?   Yes   No   If yes, what degree?

associate   bachelor   doctorate   other

What was the focus of your studies?

EMPLOYMENT (EVEN IF RETIRED)

Occupation: Employer:

full-time   part-time   employed since   student

homemaker   volunteer   retired since   disabled since

Job satisfaction level?   How long at previous job?

Other jobs:

Are you having any problems at workplace?   Yes   No

Specify:

MILITARY SERVICE

Yes   No   Type of discharge:

Exposure to traumatic events, loss of life, bloodshed   Yes   No   *If yes, please describe:*

FINANCIAL

Are your material needs met?   Yes   No

Are you having financial problems?   Yes   No

If yes, please describe:

LEGAL HISTORY

Have you ever been involved with the legal system?   Yes   No   *If yes, please describe:*

Client signature ____   Date________________

Reviewed/completed by clinician __________________________   Date________________