Extended History Form

The following questionnaire contains CONFIDENTIAL information and will only be seen by your therapist. Any duplication, transmittal, reduplication, or transfer of these records is expressly prohibited (42 C.F.R., Part 2).

Client Information

First Name	Last Name	Birth Date	Age	Sex

Street Address	City	State	Zip

Home Phone	Cell Phone	Email

Person to notify in case of emergency	Telephone	Relationship

Names, ages and genders of children

Occupation	Ethnicity	Referred By

Insurance Information

<u>Note</u>: If you intend to use Insurance to pay for sessions, you must contact your Insurance Company Plan Sponsor prior to attending your first session. Make sure you confirm that your therapist (Mindy McHugh) is on the panel for your specific plan. Ask your plan sponsor if you need authorization for your visits, if you have a yearly deductible (and the amount), how many sessions are authorized, and the amount of your copay each session. If you do not provide this information at your first session, you will be charged the full session fee.

Insurance Company	Subscriber ID	Social Security Number

Name of Primary Person on the account	Date of Birth

Number of authorized sessions	Annual deductible	Your co-pay amount each session

Relationship Information

Are you currently in a relationship? Yes No

If Yes: Married (years) Domestic Partnership (years) Dating (years)

If No: Have you been in a Long-Term relationship? Y N How long did it last? (years)

Questions for Couples Therapy

Has there ever been or is there currently any domestic violence (Physical Abuse) occurring in your relationship? _____. If Yes, describe _____

_____

What would you most like to get out of our work together? _____

_____

Describe your previous individual or couple therapy experience if you have had any: _____

_____

Attraction Phase: Describe falling in love with your partner. What were the traits he/she possessed that made you decide to connect with him/her. _____

_____

Power Struggle: (Challenges we face now...) _____

_____

What do you imagine it is like being in relationship with you? _____

_____

What are the strengths of this relationship? _____

_____

Is there anything else I need to know about you and your relationship that would be important so that I can be the most helpful? I cannot hold secrets from your partner, but I can help you tell them things you might be afraid to say to them. _____

_____

If we were to be wildly successful in our work together, what would your relationship look like and feel like when we are done? _____

_____

What am I doing that is keeping me from having the relationship that I long for. _____

_____

What is one thing I can do differently to create the relationship that I want? _____

_____

Medical Information

How many times in your life have you been hospitalized overnight for a medical condition? _____

Do you have any chronic medical conditions that continue to interfere with your life? _____

Are you taking any prescription medication on a regular basis? Yes _____ No _____

If Yes: List medication(s) for their condition(s) below:

_____

_____

Have you experienced any medical conditions in the last 30 days? _____

When was your last Medical Exam? _____

Has anyone in your family committed suicide? Yes _____ No _____

If Yes: Whom _____ When _____

Have you ever attempted suicide? Yes _____ No _____

If Yes: When was your last attempt _____

Are you currently having thoughts of committing suicide? Yes _____ No _____

Psychotherapy Experience

Have you ever seen a psychotherapist or psychiatrist in the past? _____

What for? _____

Where/by whom? _____

What kind of treatment did they offer (talk therapy, EMDR, medication)? _____

When (from – to)? _____

What was the outcome of your experience? _____

Would you describe your level of Satisfaction with your experience (Include any difficulties that you had) _____

_____

History of Abuse

Do you have any memories of any type of abuse in your past? Yes _____ No _____

Verbal? _____

Physical? _____

Emotional? _____

Sexual? _____

Neglect? _____

If so, what was the outcome of the abuse, if any (divorce, prison, etc…)? _____

Was there anyone you could rely on during the time the abuse was occurring? _____

Legal History

Have you ever been arrested or charged with a violation? Yes _____ No _____
If Yes, for what? _____

Do you have any litigation pending now, or any litigation in the past? Yes _____ No _____
If Yes, for what? _____

Drug or Alcohol Use

What is your current drug or alcohol use, including frequency?

Substance Used Amount (per week)

Alcohol _____

Caffeine _____

Tobacco _____

Marijuana _____

Cocaine/Crack _____

Inhalants _____

LSD _____

Heroin _____

Ecstasy _____

Other _____

How long was your last period of voluntary abstinence from this substance? _____

Have you ever been treated for alcohol or drug abuse or attended any 12-step programs for any type of abuse or compulsion? _____

_____

Please bring this document to your first session.