Catherine Ridder
M. Div., LMFT

Personal Information

General:

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Mobile _____

Age _____ Referred by _____ Email _____

Marital Status _____ Date of Birth _____

Occupation _____ Who lives with you? _____

Education Level _____ _____

Emergency Contact Information _____

Explanation of how patient can be contacted by the therapist _____

Financial:

Annual Household Income _____

Are you planning to use Health Insurance? _____

Name of Insurance Company _____ Policy Number _____

Group Number _____ Telephone Number _____

Areas of Concern:

What issues/concerns caused you to see treatment? Please describe. _____

_____

Do you have any specific goals with regard to your treatment? _____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

Psychological History:

Have you ever recived mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Have you ever been hostpitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hostpitalized? _____

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on these medications? _____

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Psychological History Continued:

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Have you ever attempted suicide? _____ When? _____

Describe the circumstances that led up to that attempt: _____

Are you currently having any suicidal thoughts? Please Describe: _____

Medical History:

Have you ever been diagnosed with a serious illness? Please describe: _____

_____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today: _____

_____

Family of Origin History:

Mother's name, age, living/deceased: _____

Father's name, age, living/deceased: _____

Names and ages of siblings: _____

Please indicate if there is a family history of any of the following by marking the corresponding box:

☐ Alchohol/Substance Abuse	☐ Anxiety	☐ Depression
☐ Domestic Violence	☐ Eating Disorders	☐ Obesity
☐ Obsessive Compulsive Behavior	☐ Schizophrenia	☐ Suicide Attempts

Other Information:

Please describe your spiritual identity/orientation: _____

Please describe your interests/hobbies: _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe: _____

Please feel free to use the space below to include any other information you believe is relevant to your mental health treatment that was not previously requested: _____

_____

_____

_____

_____