Marc Bachrach Therapy

Solutions for Growth and Change

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Office Use Only

Informed Consent Received/Signed: _____

Privacy Statement Received/Signed:_____

Release of Information on File:_____

Client's Name:_____ Today's Date:_____

Partner's Name (if being seen as a couple): _____

Address, City, State, Zip: _____

Home phone:_____ Work phone: _____ Cell phone: _____

Private email address:_____ Student? If yes, where and major?_____

May we leave messages for you at home? Yes / No May we leave messages for you at work? Yes / No

Gender: M / F Age:_____ Birth Date:_____ Marital Status:_____

Others Living in Home (name, age, relationship to client):_____

_____

Highest Level of Education:_____ Occupation:_____

Client's Employer: (optional)_____

Emergency Contact: _____ Relationship to client:_____ Phone:_____

Referred by/ How did you hear about our services?_____

May we acknowledge our meeting to any referral source? _____

Have you received previous counseling and/or substance abuse treatment? Yes _____ No _____

If Yes, Name & number of therapist/Agency: (optional)_____

Past Diagnoses? _____ Months / Years in treatment: _____

Name & number of primary care physician or health practitioner: (optional)_____

Name & number of psychiatrist or psychiatric nurse practitioner: (optional) _____

Any current medical or mental health conditions being treated? _____

Any current medications? Yes ___ No___ [If yes, please list & include daily dose amounts]_____

_____

Do we have your permission to discuss or receive treatment records and/or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/or to disclose or share our clinical information with your past or current therapist, psychiatrist, and/or physician? Yes _____ No_____

Signature [required] _____ **Date** [required] _____

Personal & Family Information

Ethnic identity & background _____Current relationship status_____

My birth parents currently:

married/live together ___ separated ___ divorced ____ never lived together ____ one or both deceased ____

Family of Origin [parents/step parents, adoptive parents, siblings]

Name (optional)	**Relationship to you**	**Age or deceased**

Current Family & Household [partner/spouse, roommates, children]

Name (optional)	**Relationship to you**	**Age or deceased**

Check all that apply:

(History of)	**Family of Origin**	**Current Family & Household**
Counseling		
Alcohol dependence		
Drug dependence		
Chronic physical illness		
Chronic mental illness		
Depression		
Anxiety		
Eating disorders		
Domestic violence		
Sexual abuse and/or incest		
Psychiatric hospitalization		
Suicide attempts		

(check all that apply)

• I use alcohol: never____ less than once per week____ more than once per week_____ daily____

• I use drugs: never____ less than once per week____ more than once per week_____ daily____

• I use tobacco: never____ less than once per week____ more than once per week_____ daily____

• I have experienced an unwanted sexual experience: recently___ in the past____sexual assault____ date rape____ rape____incest___

• My sleep is: _____ hours a night / Frequent waking? ___ (y/n) / Difficulty falling asleep? ___(y/n) Staying asleep? ___(y/n)

• I am dissatisfied with my personal appearance ___(y/n)

• I have felt like or tried to hurt myself in the past___(y/n) I'm currently hurting myself ___(y/n)

• I have suffered a recent significant loss or death ___(y/n)

• I have suffered a recent relationship ending ___(y/n) other loss___(y/n) (Please list)_____

• I have experienced:

___(y/n) medical complications at birth

___(y/n) serious head injury (or knocked out)

___(y/n) past learning disability or attention deficit/hyperactivity disorder

___(y/n) permanent disability (if checked yes, please describe) _____

___(y/n) legal difficulties (if checked yes, please describe) _____

Please state briefly your reasons for seeking services at this time.

_____

_____

_____

_____

_____

What do you think may be getting in the way of you resolving your current problems or concerns?

_____

_____

_____

_____

What are a few of your current goals that you wish to achieve while participating in counseling and how do you currently believe you can best achieve those goals?

_____

_____

_____

_____

How would you like things to be different after you have participated in counseling/consultation?

_____

_____

_____

_____

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?

_____

_____

_____

_____

_____