Balanced Life Therapy
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HISTORY FORM

Client's Name: ____

Age: ________ Today's Date: ____/____/____

Address: ______________________________ How long at this address? ________

City: __________________ State: __________ Zip/Postal Code: __________

Emergency contact name & phone number: ______________________________

Gender: __________________ Birthplace: __________________________

Birthdate: ____/____/_______ Race/Ethnicity: ____________________________

Email Address: ____

Educational History, please include graduation years (if applicable):

High School (name and city): ____________________________________

Vocational Training: ____

College: ______________________ Graduate School: __________________

Did you have any academic or social problems during your education? If yes, please explain:

____

____

____

____

Who referred you?

Name: ____________________________ Address / Phone : ____________________________

Permission to contact/thank referral source? (circle one) Yes No

Personal Care Physician ________________________ Phone: __________________________

Please describe the problems for which help is needed at this time.

Positive psychology: What is going well in your life? What are your strengths?

Have you ever received mental health treatment (including psychotherapy or prescribed psychiatric medication)? ☐ No ☐ Yes

If yes, please complete the following history of psychiatric/psychological treatment (including psychiatric medication prescribed by a non-psychiatrist physician such as a primary care physician).

Name of Organization/Professional	Date	Address

Current Family Stressors: Please include things such as recent death in family, relationship problems, financial problems, serious medical or psychiatric illness, job problems or unemployment, domestic violence, etc.

Trauma: Please include any traumas impacting you such as witnessing domestic or other violence, sexual, physical or emotional abuse, neglect, or accidents where you or someone was badly hurt, etc.

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____
____
____
____

Have you ever experienced sexual, physical, or emotional abuse? ☐ No ☐ Yes

Psychiatric Medication History: If you have taken psychiatric medications, please list them below in chronological order:

Drug Name & Dosage	Prescribed By & Dates Taken	Benefits & Side Effects

Therapy History:
Have you ever received mental health related therapy? ☐ No ☐ Yes

If yes, please complete the following information:

Type of Therapy & Provider	Reason for Therapy	Dates & Frequency

With whom do you live?
Name: ____________________________ Age: _____ Relationship: _______________________
Name: ____________________________ Age: _____ Relationship: _______________________
Name: ____________________________ Age: _____ Relationship: _______________________
Name: ____________________________ Age: _____ Relationship: _______________________

Other relatives or persons living in the home:

____

Family Medical History:
Do medical illnesses run in the family? (examples: seizures, thyroid problems, allergies)
☐ No ☐ Yes
If yes, please describe:

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____
____
____
____

Pregnancy, Birth, and Developmental History:
Were there any problems or abnormalities during pregnancy, birth, or development?
☐ Yes ☐ No
If yes, please describe:

____
____
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____
____

Family Psychiatric History: (Please note any that apply: Major Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Tic Disorders, Substance/Alcohol Abuse, Suicide Attempts, Eating Disorders, or other Psychiatric problems)

If any of your **biological relatives** have had psychiatric problems, please specify the problem next to the relative, if any.
Mother: ____
Father:____
Brother:____
Sister:____
Grandmother:____
Grandfather:____
Aunt:____
Uncle:____

Medical History: Please describe any medical problems that you have previously had or are currently experiencing:

____
____
____
____
____

Do you currently take any medications for a medical illness? ☐ No ☐ Yes
If yes, please describe:

____
____
____

________________________________ ______________________
Signature of person completing form Date