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Medical and Behavioral Health History

NOTICE: This Medical and Behavioral Health History is a part of your Protected Health Information, and is subject to the privacy protections described in the attached HIPAA Notice of Privacy Practices. You have the right not to complete this History, and your treatment will not be conditioned upon the completion of this History.

Today's Date: _____

Name: _____ Age: _____

Occupation _____ Do you like your work? _____

How long have you been on Maui? _____

Medical Health

Primary Care Physician (PCP): _____ Location: _____

Please list all current prescription medications:

Name of Medication	Dosage	Prescribing Doctor	When did you start taking it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any physical health problems, injuries or surgeries that you feel are important to mention?

Please indicate which of these substances you currently use:

<u>Substance</u>	<u>Amount used</u>	<u>How often?</u>	<u>How many years?</u>
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Other Drugs	_____	_____	_____

Has anyone ever told you that your should "cut down" on your alcohol or drug use? Yes No

Have you gotten sober/stopped using drugs or alcohol? ? Yes No

If yes, what and when? _____

Have you ever had an eating disorder such as anorexia, bulimia, or compulsive eating? _____

Behavioral Health

Have you ever been in psychotherapy or counseling? Yes No

If yes: With whom? _____ Duration? _____ Previous diagnosis? _____

Was it helpful? _____

Are you under the care of a psychiatrist? Yes No

If yes, whom? _____ Location? _____

Have you taken medications for psychiatric or emotional problems in the past? Yes No

If yes, describe: _____

Are you currently taking any psychiatric medications? Yes No

If yes, what? _____

Have you ever been hospitalized for psychiatric or emotional problems? Yes No

If yes, describe: _____

Have you ever tried to take your life? Yes No

If yes, when? _____

Do you currently have suicidal thoughts? Yes No

If yes, how often? _____ Do you have a suicide plan? _____

Marriage/Relationship

Current relationship status: Single Married Living as married

In relationship but not living together Separated Divorced

Have you been married before? Yes No If yes, how many times? _____

(Skip to next section if you are not in relationship)

How many years have you been in your current relationship? _____

Is your relationship Happy Fair Unhappy

Are there any concerns in your relationship? (e.g. alcohol or substance use, infidelity, parenting, domestic violence, anger issues)

Information About Children

Do you have children? Yes No If yes, list all your children:

Name	Age	Sex	Living where/with whom?	Are you close?

Family of Origin History

What was it like growing up in your household? _____

Whom were you closest to when you were growing up? _____

Were your parents divorced? Yes No If yes, how old were you at the time of divorce? _____

And whom did you live with when growing up? _____

Is your mother still alive? Yes No If yes, living where? _____ Are you close? _____

Is your father still alive Yes No If yes, living where? _____ Are you close? _____

What is your birth order? Oldest Middle Youngest If a middle child, what # in the middle? _____

List your brothers and sisters in birth order:

Name	Sex	Living where?	Are you close?

In your family of origin (parents, siblings) is there a past or current presence of:

Alcohol or substance abuse: Yes No If yes, who? _____

Mental illness/emotional problems: Yes No If yes, who? _____

Chronic physical illness/disability: Yes No If yes, who? _____

Abuse (verbal, physical, sexual): Yes No If yes, who? _____

As a child, did you experience Physical abuse Sexual abuse Neglect Emotional or verbal abuse

If yes, duration and by whom? _____

Please mention any other aspects from your family of origin that may be important for your therapy.

Other areas

Do you have a spiritual practice? Yes No If yes, what? _____

How long have you done this practice for? _____

What do you do for fun? _____

Checklist of Concerns

Please check all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues" You may add a note or details in the space next to the concerns checked.

- | | |
|--|---|
| <input type="checkbox"/> Anger, irritability, temper, outbursts, arguing | <input type="checkbox"/> Obsessions, compulsions |
| <input type="checkbox"/> Anxiety, fears, worries, nervousness, phobias | <input type="checkbox"/> Panic or anxiety attacks |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Parenting, children, step-children |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Self-confidence, self-esteem |
| <input type="checkbox"/> Finances, money | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Health problems, physical symptoms, illnesses | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Legal matters, charges | <input type="checkbox"/> Self mutilation |
| <input type="checkbox"/> Life meaning and purpose, spirituality | <input type="checkbox"/> Stress, tension |
| <input type="checkbox"/> Loneliness, isolation, withdrawal | <input type="checkbox"/> Suicidal thoughts/feelings |
| <input type="checkbox"/> Loss, grieving, separation, divorce | <input type="checkbox"/> Trauma/abuse |
| <input type="checkbox"/> Low energy, tiredness, fatigue | <input type="checkbox"/> Weight & diet issues (overeating, undereating, appetite, vomiting, body image) |
| <input type="checkbox"/> Menstrual problems, PMS, menopause | <input type="checkbox"/> Work problems, employment, career choices |
| <input type="checkbox"/> Mood swings | |

Any other concerns or issues not on the previous checklist?



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Why are you seeking counseling at this time? _____

What are your goals for therapy? What do you want to accomplish?

Is there anything else you want me to know about you?

Client Signature

Date

Mahalo for your time.