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Patient Registration

All of the information requested on the following pages is designed for your therapist to get a better understanding of your life history as well as that of current life stressors. Please fill out these pages with as much thought and care as possible. All information remains in the strictest of confidence.

Date of First Session _____

Last Name _____ First Name _____ Middle Initial _____

Is there a name you prefer being called? _____ D.O.B. _____

Gender _____

Address _____ City _____ State _____ Zip _____

Phone #s Home _____ Cell _____ Work _____

Profession _____ Location _____

Additional Employment (if Applicable) _____

Current Marital Status _____

Name of Spouse/Partner _____ Length of Relationship _____

In Case of Emergency call: (Name, Relationship,
Telephone) _____

Personal Physician (Name, address, telephone)

Do you have any children? (Give Names and Ages)

Referred By: _____

Mental Health/Medical History

(Please circle Yes/No and provide detailed information when requested)

- History of either acute or chronic physical illness? **Yes No**
- History of mental distress/illness for which professional attention has been received? Include any diagnosis given by a physician or mental health professional regardless of severity of symptoms. **Yes No**
- Family history of either physical or psychological problems, which require significant medical attention? **Yes No**
- Do you have any known allergies or allergic reactions to food or medications? **Yes No**
- Prior hospitalizations or surgeries (medical, psychiatric and/or cosmetic) **Yes No**
- Are you currently taking any medication on a regular basis? (prescribed, over the counter, homeopathic) **Yes No**
- Overall, during the past year, did you sense a change in your total physical and/or emotional well being? **Yes No**

For all checked yes, please provide additional pertinent information such as specific diagnoses, age of onset, treatment received, medications prescribed, length of hospitalizations/treatment

Birth History – Please describe what you know about your birth (ie on-time, premature, c-section, any complications etc.)

When was you last *complete* physical examination? _____

Drug /Alcohol Intake

Do you consume drugs (incl. marijuana) and/or alcohol? **Yes No**
(If Yes please specify)

Describe your average consumption of each of the above substances in any give week.

Do you believe or has anyone ever told that they believe your consumption has ever crossed the line in to dependency? **Yes No**

If **Yes** please explain) _____

Family of Origin

Growing up, were your parents: **Married** **Divorced** **Widowed**

With whom did you live growing up? _____

Briefly describe nature of your relationship with your mother, father and/or primary caretaker(s)?

Are your parents currently living? **Yes No** (If No please indicate year of death, age and cause of death)

Please list other significant adults in your life growing up and nature of your relationship with them?

Please list names/ages of siblings? (If deceased please also include year of death, age, and cause of death)

Education

Highest level of education? _____

Throughout your school years, what kind of grades did you achieve?

- Did you ever drop out of school or was your education ever interrupted? **Yes No**
- Were you ever placed in special classes? **Yes No**
- History of learning disability? **Yes No**
- Were you ever involved in military service? **Yes No**
- Did you experience any difficulty with peer relationships **Yes No**
- Did you experience any difficulty with relationships with your teachers **Yes No**

If Yes to any of above questions, please explain and or/describe nature of situation _____

Sexuality

How do you define your sexual preference? _____

- Has there ever been any ambivalence/change with this preference? **Yes No**
- (If yes, please elaborate)

- Please indicate level of your sexual feelings. **Moderate Intense Somewhat repressed**
- Does this affect your interpersonal relations? **Yes No**
- Are there any recent changes in these feelings? **Yes No**
- Have you ever experiences any unwanted/uninvited sexual contact? **Yes No**

If Yes to any of above please indicated circumstances, and where applicable circumstances/nature of relationships with individual(s) involved

*Marriage and/or Significant Other

(*Consider in terms of sharing a home/ being in a committed relationship)

Are you *Single* *Married* *Divorced* *Separated* *Widowed*?

Please list dates of marriage(s) and, if applicable divorce, and reason for divorce).

If not married are you currently in a relationship? *No Yes* (Please describe)

Are there any areas of dissatisfaction in your current marriage/relationship? *No Yes* (Describe)

Do you describe your relationship as monogamous or as more "open"? (Explain)

Have there been extramarital affairs that have not been sanctioned by the relationship? (Elaborate to the best of your comfort level)

Children

Please list names and ages of your children

If you have concerns or difficulties in your relationship(s) with any of your children, please describe briefly

Are there any aspects of your parenting style or ability with which you are dissatisfied? If yes, how would want it to be different?

Occupation

- What is your current occupation? _____
- Please indicate duration of current occupation? _____
- Are you currently unemployed? *Yes No*
- Are you currently experiencing any difficulties functioning adequately at work? *Yes No*
- What is your approximate annual income? _____
- Does this present you with any difficulty meeting your expenses? *Yes No*
- Are you experiencing any difficulties/ dissatisfaction with your current occupation/employment? *Yes No*
- Do you experience any difficulties getting along with your co-workers? *Yes No*
- Is there any recent change to the nature of these relationships? *Yes No*

If *Yes*, please elaborate and indicate nature of difficulties

Community/Spiritual beliefs

- Do you have any close friends in whom you can confide? **Yes No**
- Do you have any pets? **Yes No**
- Are you active in a church, synagogue or other spiritual practice? **Yes No**
- If **Yes** please describe _____
- Do you have a spiritual connection? (Please indicate any personal connection - not necessarily related to the practice/adherence to any specific religion/doctrine) **Yes No**
- If **Yes**, what do you call your spiritual connection? (ie God, The Universe, Jesus, Nature etc)
- _____
- Are your current spiritual beliefs consistent with religious/spiritual teachings with which you were raised? **Yes No**
- If **No** what (if any) was the religion/spiritual teachings with which you were raised?

Please list clubs or organizations to which you belong

How do you like to spend your leisure time?

Is this how you do spend your leisure time?

Current Living Conditions

Describe your current home

How long have you lived there? _____

Do you feel that your living quarters are comfortable and that you have enough space?

With whom, if anyone do you live?

Is this living arrangement satisfactory? **Yes No**

Symptoms

What are the problems/symptoms that brought you here?

How long have you been dealing with these issues? _____

Have you had similar problems in the past? How did you deal with them?

What would you like to achieve in our time together?

Is there anything else that it would be important for me to know about you or your history?
