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Your Family in Balance
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Review of Concerns

Name: _____ **Date:** _____

A. Most Recent Former Therapist / Psychiatrist:

Name: _____ **Date last visited:** _____

Address: _____

Phone: _____

Please indicate any phone restrictions: _____

No contact will be made without express written permission.

B. List any medications currently or previously taken for psychiatric or emotional concerns:

When?	*Prescribing Physician*	*Medication Name*	*To address what?*	*Results?*

C. Primary Concern:

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

_____

_____

D. Treatment History:

Have you ever received psychological, psychiatric or psychiatric hospitalization services before? ☐yes ☐no

Please describe:

When? From whom? For what? What were the results?

_____

_____

_____

This information is maintained in confidence in your record.

Disclosure of information only occurs with express written permission via a Release of Information form.

A. Relationships in your life:

Please describe:

Your parents' relationship with each other: _____

Your relationship with each parent and other familial adults: _____

Your or your family health problems, chemical use, mental or emotional difficulties: _____

Your relationship with your siblings, past and present: _____

Your relationships with your children: _____

Your support network of friends:

Names	Strengths of your relationship	Challenges of relationship

B. Abuse History:

☐ I was not abused in any way. ☐ I was abused. If you were abused please indicate the following:
P=physical, S=sexual, E=emotional, N=neglect

Age experienced	Abuse type	By whom?	Effects on you?	Who did you tell? Consequences

C. Substance Use:

Have you ever felt the need to cut down on your drinking or substance use? ☐yes ☐no
Have you ever felt annoyed by criticism of your drinking or substance use? ☐yes ☐no
Have you ever felt guilty about your drinking or substance use? ☐yes ☐no
Have you ever taken a morning "eye opener"? ☐yes ☐no
Have you ever had any legal issues due to drinking or substance use? ☐yes ☐no

How much alcohol do you consume a week on average? _____

How much tobacco do you consume a week on average? _____

How much of other substances do you consume a week on average? _____

Which drugs (other than prescribed medications) have you used in the last ten years? _____

Please provide details: _____

D. Other:

Are there any other pertinent issues or concerns you would like to share, including legal matters, custody issues, symptoms, etc: _____

E. What do you hope to gain from therapy?