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Encino, CA 91436
lynnkrown@gmail.com
www.lynnkrown.com
818-754-8277 tel.
818-301-2272 fax.

DATE:

NAME: **DOB:**

ADDRESS:

PHONE WK: **PHONE HOME:** **PHONE MOBILE:**

EMAIL:

OCCUPATION:

SEX (AT BIRTH) M F

LIVING ARRANGEMENT: (WHO DO YOU LIVE WITH?)

MARITAL/RELATIONSHIP STATUS (CIRCLE): MARRIED? SINGLE? DIVORCED?

WHAT IS YOUR REASON FOR SEEKING TREATMENT AT THIS TIME? (IN A FEW SENTENCES)

_____

_____

_____

_____

NAMES AND AGES OF SIBLINGS:

NAMES AND AGES OF PARENTS IF LIVING?

IF PARENT ARE DECEASED AT HOW OLD WERE YOU WHEN THEY DIED?

PARENTS AGE AT TIME OF DEATH AND CAUSE OF DEATH?

NAMES AND AGE OF YOUR CHILDREN IF APPROPRIATE?

BEHAVIORAL HEALTH HISTORY:

DATES OF CURRENT OR PREVIOUS TREATMENT?

NAME(S) OF THERAPIST?

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING?

LIST OF ANY CURRENT PSYCHOTROPIC MEDICATIONS:

PAST PSYCHOTROPIC MEDICATIONS:

LIST HOSPITALIZATIONS (DATE AND REASON):

DESCRIBE HOW YOU USE ALCOHOL OR DRUGS? FREQUENCY AND AMOUNT (CURRENTLY AND /OR PAST)? SOCIALLY? MODERATELY? DAILY?

_____

_____

_____

DESCRIBE ANY HISTORY OF TRAUMA (EX. HEALTH/CHILDHOOD HISTORY/ ILLNESS IN FAMILY/RELATIONSHIP ENDING/FAMILY ISSUE/ACCIDENT/HEAD INJURY/FINANCIAL)

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