Trauma Informed Therapies

Personal Information Form

This information is used in conjunction with the diagnostic assessment

Please provide the following information for intake purposes and for our records. Leave blank any question you would rather not answer or would prefer to discuss in person with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy. For adolescent clients 13 years old and older, please have the client, not the parent/guardian, fill out and sign these documents.

Client Name (legal):____Date of Birth:________________

Gender given at birth:_________________________ Client's Gender Identity:_____________________________

Client's Preferred Pronouns:____

Sexual Orientation:_____________________ Client's primary spoken language:____________________________

Client's Home Address:____

Client's Mailing Address:____

Client's Phone Number: (Cell)___________________________ (Home)__________________________________

Client's E-mail Address:____

Client's Employer (Company/Supervisor):____

Work Address:______________________________ Work Phone Number:_____________________________

Emergency Contact Information:

Name:_____________________________________ Relationship to you:______________________________

Address:____

Do you share an address with this contact? Yes No (circle one) Phone Number: (___)_________________________

Name:_____________________________________ Relationship to you:______________________________

Address:____

Do you share an address with this contact? Yes No (circle one) Phone Number: (___)_________________________

The following information helps us get a better picture of your situation, concerns, and needs.

Background

What prompted you to schedule an intake with Trauma Informed Therapies?

____

____

Have you received therapy/counseling before? Yes No (circle one) **If yes, please fill out addendum form on the last page.**

Have you ever been prescribed psychiatric medication (e.g. an antidepressant)? Yes No (circle one)

If yes, please describe when and for what purpose psychiatric medications were prescribed as well as dosages, if known. Include and indicate any psychiatric medications being taken currently:

____

____

Have you ever attempted suicide? Yes No (circle one)

Have you ever been psychiatrically hospitalized? Yes No (circle one)

Do you have a current or existing crisis plan with an outpatient provider*? Yes No (circle one) **If yes, please provide TIT with a copy of this paperwork.*

Have you ever had/have PTSD? Yes No (circle one)

Have you ever been sexually abused or witnessed sexual abuse? Yes No (circle one)

Have you ever been physically abused or witnessed physical abuse? Yes No (circle one)

Have you ever been emotionally abused or witnessed emotional abuse? Yes No (circle one)

Have you ever been neglected or witnessed neglect? Yes No (circle one)

Do you have any present or past difficulties with impulsive behaviors (check all that apply): __Shoplifting/Stealing __Problem/Pathological Gambling __Compulsive sexual behavior __Compulsive shopping __Other:__________________________

Substance Use/Treatment

Do you drink alcoholic beverages? __Never __Per day: ___units __In a week: ___units __In a month: ___units

Do you currently use cannabis? __Never Type of Ingestion: ____

__Per day: ___times __In a week: ___times __In a month: ___times

Do you currently use street drugs or use any prescription drugs not as prescribed?

__Never __Per day: ___times __In a week: ___times __In a month: ___times

Do you smoke cigarettes or use tobacco products?

__Never __Per day,___units __In a week: ___units __In a month: ___units

Do you ingest caffeine? __Never __Per day: ___units __In a week: ___units __In a month: ___units

If you or anyone else has been concerned about your drinking or drug use, describe what help you sought/are seeking:

____

Physical Health

Any current or ongoing medical concerns:

____

Who is your primary health care provider (i.e. physician, nurse, OB/GYN)?____

When was your last physical?____

Have you ever been hospitalized? Yes No (circle one)

Have you ever had surgery? Yes No (circle one)

Are you currently pregnant? Yes No (circle one)

If yes, has there been any prenatal exposure to drugs or alcohol? Yes No (circle one)

Please list any non-psychiatric prescription medications, over-the-counter drugs, vitamins, and/or herbal supplements that you currently take and dosages, if known:

____

Any allergies to food, drugs, or environmental sensitivities (i.e.- sensitivity to fragrance):

____

History

Where were you born and where were you raised?

____

Who were your primary caregivers as a child (i.e. who raised you?)______________________________

What were your parents'/guardians' occupations when you were growing up?

____

How many children are in your family of origin?____________ Where do you fall in birth order (first, middle, etc.)?______________

Please indicate the presence of the following conditions in your history or your family's history:

Condition	*You*	*Biological Mother*	*Biological Father*	*Biological Sibling*	*Grandmother (maternal)*	*Grandfather (maternal)*	*Grandmother (paternal)*	*Grandfather (paternal)*	*Other (please indicate relation)*
Depression									
Anxiety									
Eating Disorder									
Bipolar Disorder									
Drug/Alcohol Problems									
Suicide or Suicide Attempt									
Psychiatric Hospitalization									
Allergies									
Alzheimer's or other Dementia									
Asthma									
Cancer									
Developmental Disability									
Diabetes									
Epilepsy									
Heart Disease									

High Cholesterol									
High Blood Pressure									
Obesity									
Stroke									
Other:________									

Current Life Situation

Present Relationship Status: ___single ___married ___committed relationship ___legally separated ___divorced ___domestic partnership

Who do you live with?

Name	*Age*	*Relationship to you (e.g. mother, friend, etc.)*

Housing Status: ___ House/Renting ___ House/Own ___ Apartment/Renting ___ Apartment/Own ___ Homeless

___ Other:____

Do you believe that your basic needs are being met (i.e. clothing, shelter, etc.)? Yes No (circle one)

If no, please explain:

____

____

Do you feel safe in your home? Yes No (circle one)

Do you feel you have a sufficient social support system? Yes No (circle one)

Do you confide in them about your problems? Yes No (circle one)

Were your developmental milestones delayed or missed (i.e. walking, toilet training, talking, etc.)? Yes No (circle one)

If yes, please explain:____

What is your highest level of education? __ High School Diploma __ Some College __ Associate's Degree __ Bachelor's Degree

__ Graduate Degree __Doctorate __ Other:____

Do you have any current literacy / reading issues?____

Do you need the use of assistive technology? __Yes __No If yes, please explain:

What is your current employment status? __ Employed Full-Time __Employed Part-Time __Unemployed __Retired

If employed, what is your current occupation?____________________

How satisfied are you with your current job?____________________

Have you ever received or do you currently receive financial assistance? __Yes __No If so, please describe:

Legal History: __Criminal __Order of Protection/Restraining Order __Commitment __Guardianship __Other

If yes to any of the above, please describe:

Please indicate if you are currently involved with and/or have the following:

- Powers of attorney: __Yes* __No
- Are you under civil or criminal court ordered mental health treatment: __Yes* __No
- Letters of guardianship / parenting plans / court order for custody: __Yes* __No
- Supervision by the department of corrections: __Yes* __No
  **If answered yes to any of the questions above, please provide TIT with all relevant legal documents/paperwork*

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your service preferences:

Please indicate your ethnicity / cultural / tribal affiliation identification:

What areas are stressful in your life? (i.e. finances, career, relationship, health, school, etc.):

Please describe attributes or characteristics that you view as personal strengths:

Hobbies / Abilities / Interests:

Is there anything else you feel it is important for us to know right now?

Notes for any questions or comments for TIT or personal therapist:

____

____

____

Past Mental Health and Treatment History:

Please include all treatment and services received within the last 5 years and any highly significant treatment received within the history of your life.

Approximate Start/End Dates	**Type of Treatment** (individual therapy, inpatient, residential, intensive outpatient, family, etc.)	**Name of Provider and Clinic/Facility**	**Address and Phone Number**	**For Provider Use Only**
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	__ ROI on file, request sent to provider Date sent:_____________ __ Client declined to release information
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	__ ROI on file, request sent to provider Date sent:_____________ __ Client declined to release information
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	__ ROI on file, request sent to provider Date sent:_____________ __ Client declined to release information

SIGNATURES

My signature below indicates that I have been provided with a copy of this document, I have read and understand it, I was able to ask questions about its contents, and I consent to treatment by Trauma Informed Therapies. My signature also indicates that I have been provided with a copy of the Notice of Privacy Practices *and* Statement of Client Rights and Responsibilities.

Client Signature:____ Date:_______________________

Client Name (printed):____Date of Birth:_________________

Parent/Guardian Signature*:____Date:_________________

Parent/Guardian Name (printed)*:____

**Required if client is a minor and under the state-mandated age of consent. Age of consent is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent. For questions on your state's minor consent laws, please see the TIT Front Desk staff*