Tamara Allen Bush LLC

Tamara Allen Bush, LPC-S, CSAT-S, CMAT, ICGC-1

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Patient History Form

Date: _____

Name: _____ DOB:_____

Phones – Home: _____Cell: _____

E-mail Address: _____Work: _____

Drivers License /ID#: _____ State: _____

Address: _____

County: _____ Street, City, Zip: _____

_____

Preferred Method of Contact: Email Phone Call Txt

How were you referred to this office:

_____

Emergency Contact: _____

Contact Phone: _____ Relationship: _____

Are you employed, student or other:

_____

Are you currently on any medications? Yes: _____ No: _____

If yes, please list using back of page if needed:

_____

Name of Prescribing Physician(s):

_____

Phone or Address, City, State, Zip:

_____

CHECK IF YOU HAVE BEEN TREATED FOR ANY OF THE FOLLOWING

Drug Addiction ____ Alcoholism ____ Bipolar Disorder _____ Depression _____

OCD _____ PTSD _____ Trauma _____ Dissociative Disorder _____

Eating Disorder _____ Psychosis _____ Accidents _____ Medical _____

Medical Issues:

_____
_____
__ Primary Care Physician: _____ Phone: _____ HAVE YOU BEEN IN COUNSELING BEFORE ? Yes _____ No _____

If yes, please list the name of the counselor(s) and the dates using the back of the page if needed.

CURRENT REASON (S) YOU ARE SEEKING COUNSELING:

_____
_____
_____

_____
_____
_____

_____
_____
_____

CURRENT RELATIONSHIP – PLEASE CHECK ONE BELOW

Married ___ Separated ___ Divorced ____ Widowed ____ Dating ____

Co-Partnership with Shared Living Arrangement _____ without Shared Living Arrangement ____ Single _____ Other ____.

Name of individual: _____ How long in relationship?: _____

LIST THE PREVIOUS SIGNIFICANT RELATIONSHPS. DESCRIBE THEM AND HOW THEY ENDED. Please indicate domestic abuse if that occured (*).

NAMES AND AGES OF ANY CHILDREN:

Name/Age/Living Arrangements

ANY BEHAVIOR PROBLEMS?

EDUCATIONAL EXPERIENCE AND DEGREES :

WHAT CAREER GOALS DO YOU HAVE?

HOW IMPORTANT IS SPIRITUALITY IN YOUR LIFE? PREFERRED DEMONINATION? PREFERRED SEXUAL ORIENTATION?

LIST ANY PREVIOUS OR ONGOING LEGAL ISSUES: _____

ARE YOUR PARENTS LIVING? MOTHER _____ FATHER _____

ARE THEY TOGETHER? WHEN DID THEY SEPARATE, DIVORCE OR BECOME WIDOWED?

LIST 5 WORDS THAT DESCRIBE YOUR MOTHER WHILE YOU WERE A CHILD:

LIST 5 WORDS THAT DESCRIBE YOUR FATHER WHILE YOU WERE A CHILD:

BEST EXPERIENCE OF YOUR LIFE?

WORST EXPERIENCE OF YOUR LIFE?

WHAT WOULD YOU LIKE TO SEE ACCOMPLISHED THROUGH COUNSELING?

PLEASE LIST BELOW ANY OTHER INFORMATION THAT YOU THINK WOULD BE HELPFUL FOR YOUR COUNSELOR TO KNOW.