Jacqueline Shea Vance, LCSW
Licensed Psychotherapist (LCS20378)
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ADULT INFORMATION & HISTORY

Today's Date:

Personal Information

Name

Home Address

City/State/Zip

Your Email

Contact Number

Date of Birth

Marital Status

Name of Spouse/Partner

How many years

Highest Grade/Degree

Occupation

Employer/School

Work Address

City/State/Zip

May I call you at your contact number? yes no

Person completing form (if other than patient):

Relationship:

Name of Guardian (if applicable):

Emergency Information

Contact person in case of emergency: Relationship:

Phone #:

How did you find Jacqueline Vance, LCSW?

Physician Information

Primary Care Physician:
Phone Number:
OB Gyn:
Phone Number:
Reproductive Endocrinologist or Fertility Specialist:
Phone Number:

REASON FOR VISIT

Please describe your PRIMARY reasons for seeking therapy/counseling (include year/month the difficulties started):

Was there a significant event which made these issues or problems surface? Yes No
If yes, describe:

What motivated you to get help now?

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:
(Place an X in the appropriate box)

	No Effect	Little Effect	Some Effect	Much Effect	Significant effect	Not Applicable
Marriage						
Family						
Job or School Performance						
Friendships						
Hobbies						
Financial Situation						
Physical Health						
Anxiety level						
Mood						
Eating habits						
Sleeping habits						
Sexual functioning						
Ability to concentrate						
Ability to control your temper						

Please answer whether or not you are CURRENTLY experiencing any of the following symptoms:

Suicidal Thoughts/Impulses ..... N____ Y____

Homicidal Thoughts/Impulses ..... N____ Y____

Appetite Problems ..... N____ Y____

Sleep Problems ..... N____ Y____

Physical Complaints ..... N____ Y____

Anger/Irritability ..... N____ Y____

Isolation/Social Withdrawal ..... N____ Y____

Anxiety/Panic ..... N____ Y____

Phobia ..... N____ Y____

Bingeing/Purging ..... N____ Y____

Poor Impulse Control ..... N____ Y____

Violence Toward Others ..... N____ Y____

Destruction of Property ..... N____ Y____

Strange or Unusual Behavior ..... N____ Y____

Confused or Irrational Thinking ..... N____ Y____

Bothersome Repetitive Thoughts or Behaviors N____ Y____

Self-mutilation ..... N____ Y____

Psychiatric History

Have you received any Psychological/Psychiatric treatment before? No___ Yes___

What was your age at the first visit? _____

If you checked Yes to the above question, please answer the following for the most RECENT TREATMENTS:

What type of care did you receive? Inpatient (hospital) Outpatient Both

When were you in treatment?

Where were you in treatment?

How long were you in treatment?

How helpful was it?

How and why did it end?

Who was your therapist and psychiatrist?

Did your psychiatrist prescribe medicine at this time? Yes No Not applicable

If yes, what was prescribed (include dosages if known) ?

Substance Use History

How much alcohol do you drink per week on average? ____ drinks per week

How much alcohol did you drink per week on average for the last 5 years? _____ drinks per week

Have you had problems with your drinking (legal, health, work, relationship?)

No___ Yes___ If Yes, please explain:

Have you had any inpatient/hospital treatment for substance abuse?

No___ Yes___

[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]:

Did you or do you use any illicit drugs? Yes No

Please list:

PAST	PRESENT
_____	_____
_____	_____
_____	_____

Please describe the alcohol and/or drug use for your PAST and PRESENT USE:

Substances	Amount	Frequency	When? (first use, last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have a history of blackouts, seizures, or withdrawal symptoms? Yes No

Habits:	**Amount Currently Using**	**Most Ever Used**
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____

Medical History

Current Medical Condition(s):

Please list any prescription medications you currently use:

NAME	DOSAGE	FREQUENCY

Please list any over-the-counter medications you CURRENTLY use:

NAME and DATE BEGAN	DOSAGE	FREQUENCY

Please list any past or present MEDICAL conditions that you have been treated for:

Have you ever had a brain injury or a neuropsychological exam? Yes No
Please describe:

When did you last have a physical examination?

Who did you see?

Name Phone Number

Reproductive Health History

Please list pregnancies, births, miscarriages by most recent date:

Please describe history of infertility treatments, including reproductive medicine and holistic:

Procedure Date Specialist

Past and Present Marriages (Name of partner, number of years together)

Family History

How many siblings do you have? Full _____ Half _____ Step _____

How many times was your mother married? _____

How many times was your father married? _____

If your parents divorced, include your age at the time and describe how it affected you:

Describe your childhood in general: Relationships with parents, siblings, others, school, neighborhood, relocations...

Describe any significant conditions of your parents and/or other family members:

Emotional:

Medical:

Chemical dependency:

Developmental History

Did you experience any type of developmental delays as a child? Please describe:

Did you experience any type of learning difficulty or academic difficulty as a child? Please describe:

What gives you most joy or pleasure in life:

What are your main worries and fears:

What are your most important hopes or dreams:

Friendships/Community/Spirituality: (Describe quality, frequency, activities, etc.)

Goals Please list your primary goals for treatment in order (begin with the most important):