Body & Soul Therapy

2045 Maybank Hwy., Charleston, SC 29412 • 843-795-1100

Patient History Form

Date_____ Social Security #_____Referred by_____

Name_____DOB___/___/____Age____Sex__
(First) (Last) (Middle Initial)

Address_____
(Number and Street) (City and State and Zip Code)

E-mail address/ home_____E-mail address/work_____

Telephone: Day _____Evening_______Cell_____

Health insurance company_____Policy ID and Group #_____

Policy Holder_____DOB___/___/___Place employed_____
(First) (Last) (MI)

Marital status: Single___ Married___(How long?____) Separated___(How long?____)

Divorced____ (How long?____) Widowed___(How long?____)

Living with?_____ _____ # of children?_____ #of Siblings?_____

Hobbies/Interests/Strengths?_____

_____

Last year of schooling completed_____Occupation_____

Name/address of employer_____

_____Telephone_____

Your spouse/partner's occupation/employer?_____

Family history of addictions, emotional/mental problems?___ _____

_____

Are you receiving or seeking disability? _____ Type?__ _____

Previous psychotherapy?_____ Why?_____When?___ _____

Therapist name, address and telephone number_____

Name and telephone number of your physician_____

Have you ever had a seizure, serious brain concussion or a stroke? _____

Current and chronic illnesses?_____

Current medications?_____Last physical exam?_____

Current/Previous Symptoms :

Sleeping Problems? ____ Eating Problems?____ Anger?____ Sexual Problems?____

Use of Alcohol/Recreational Drugs?____ Worries/Fears____ Learning Problems? ____

Suicidal Thoughts/Attempts____ History of Physical/Emotional/Sexual Abuse?____

Depression?____ Trauma?____ Physical Problems?____ Addictions?____

Explain:_____

_____

Reason for seeking counseling?_____

_____

Person to reach in case of an emergency: _____ Relationship?_____

Telephone number: Day_____Evening_____